

# Metabolic Journey Questionnaire

## Personal Information

\* Indicates required question

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1. Full Name \*

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2. Date of Birth \*

*Example: January 7, 2019*

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3. Email \*

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4. Phone number \*

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5. Occupation \*

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6. Preferred Language \*

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**7. Relationship Status**

*Mark only one oval.*

Single

Married

In a relationship

**8. Self-reported height (cm):**

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**9. Self-reported weight (kg):**

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**10. BMI (if known):**

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**11. Recent changes in your weight over the past 6 months: please specify any gains or losses - write N/A if unsure**

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**12. Self reported recent BP**

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**13. Self reported recent heart rate**

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**14. Do you have any medical illness ? \***

*Check all that apply.*

- Type1 or Type2 DM
- Hypothyroidism/Hyperthyroidism
- High BP
- High Cholesterol
- Fatty Liver
- Any hormonal issue
- Any other
- Other: \_\_\_\_\_

**15. Have you had any surgeries ? \***

Please list with dates -

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**16. Family Medical History - Has anyone in your family (siblings, parents or grandparents) been diagnosed with - \***

*Mark only one oval.*

- Obesity
- Diabetes Mellitus
- High BP
- Heart Condition
- Cancer
- Stroke/ Other Neurological Conditions
- Autoimmune Disorder
- Other significant condition

17. Are you on any regular medication? \*

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18. Any history of allergy to food, drug or any chemical? \*

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### **Metabolic Symptoms**

## 19. In the past 3 months, how often you have experienced the followings- \*

Mark only one oval per row.

	never	occasionally	frequently	daily
<b>Fatigue or low energy</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Craving for sugar or carbs</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Feeling hungry soon after eating</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Brain fog or poor concentration</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Mood swings or irritability</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Bloating or digestive issues</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Difficulty losing weight</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Trouble falling or staying asleep</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Lifestyle Domains**

## 20. What are the Physical Activities you are currently engaged in ? \*

*Check all that apply.*

- Swimming
- Sports
- Workouts ( Gym/Mat Exs/Group classes)
- Cycling/ walks

## 21. How many hours a week do you engage in the above activities ? \*

## 22. How many steps do you take every day : \*

*Check all that apply.*

- < 5,000
- 5,000 - 7,499
- 7,500 - 9,999
- ≥ 10,000
- ≥ 12,500

## 23. How many hours on average do you sit each day? \*

## 24. Are you a \*

*Mark only one oval.*

- Vegetarian ( a person who doesn't eat meat, poultry and seafood)
- Vegan (a person who doesn't eat animal milk, eat meat, poultry, and seafood)
- Non-vegetarian (a person who eats meat, poultry and seafood)
- Ovo-vegetarian ( a person who is a vegetarian but eats eggs)

## 25. On a usual day, how many meals do you have : \*

*Check all that apply.*

- Early morning (before breakfast: Tea, nuts, fruits etc.)
- Breakfast
- Lunch
- Evening Tea
- Dinner
- Bedtime

## 26. How many glasses of water do you drink per day? \*

*Mark only one oval.*

- <5
- 5-10
- >10

## 27. Who prepares your meals most of the time? \*

*Mark only one oval.*

- Self
- Family member
- Cook
- Outside/Takeaway

## 28. How often do you eat takeaway/outside? \*

*Mark only one oval.*

- Daily
- 2–3 times/week
- Once a week
- Occasionally

## 29. Do you follow any special diet among the following? \*

*Check all that apply.*

- Gluten-Free
- Low/No Carbohydrate Diet
- Intermittent Fasting
- Low Salt Diet
- Lactose-Free
- Keto-Diet
- No Special Diet
- Other: \_\_\_\_\_

## 30. How often do you consume the following foods? \*

*Mark only one oval per row.*

	Daily	2- 3x/week	Sometimes	Never
<b>Whole grains (atta, millets - bajra, jau, jowar etc, Oats, Quinoa)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Dairy (milk, curd, yogurt, paneer, cheese)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Pulses and legumes (dals and beans)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Red meat (mutton, pork etc.)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Fish and seafood</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Vegetables (raw and cooked)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Fruits (raw and cooked)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sweets (Indian sweets and confectionery)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Fried foods (Indian savouries, other snacks)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Outside meals (Lunch, Dinner, Breakfast or evening/morning snacks)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. What type of nutritional supplements do you consume? \*

*Mark only one oval.*

- Multivitamins
- Vitamin D
- Vitamin B12
- Calcium
- Iron
- Omega-3 / Fish oil
- Protein supplements/ powders (e.g., whey, plant-based)
- Probiotics
- Ayurvedic or herbal supplements
- Meal replacement shakes or bars
- Weight loss supplements
- None
- Other: \_\_\_\_\_

32. On an average, how many hours do you sleep at a stretch in a day \*  Dropdown  
?

*Mark only one oval.*

- Less than 6 hours
- 6-7 hours
- 7-8 hours
- More than 8 hours

33. How would you rate quality of your sleep ? \*

1    2    3    4    5



34. Do you wake up during the night ? If yes, how often and why ? \*

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35. Do you experience daytime sleepiness ? \*

*Mark only one oval.*

- Not at all
- Occasionally
- Several days
- Nearly every day

36. How would you rate your overall emotional well-being ? \*

1    2    3    4    5



37. Do you smoke cigarette ? \*

*Mark only one oval.*

- No
- Yes

38. Do you drink alcohol ? \*

*Mark only one oval.*

Yes

No

## Goals & Motivation

39. How important is it for you to make healthy lifestyle changes ? \*

1    2    3    4    5

☆ ☆ ☆ ☆ ☆

40. How confident are you in your ability to make those changes ? \*

1    2    3    4    5

☆ ☆ ☆ ☆ ☆

41. What do you feel is your biggest barrier to reaching your goals?

\_\_\_\_\_

42. How many times a week you can spend time with us- \*

*Mark only one oval.*

Once a week

2-3 times/ week

Flexible hours

Preferred time- Morning/evening

43. Where do you wish to see yourself in 3 months time \*

(in relevance to your Goals & Ability) :

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