LIFESTYLE Questionnaire and assessment of habits that may lead to illness and impa	ment of habits that may lead to illness and impair quality of life				
Name:	Date of Birth:	_/	J		
Start Date of Follow-up:/					



NOTE: Lifestyle habits that need improvement are those in the second column (gray).

Questions	We	ek 1	We	ek 2	We	ek 3	We	ek 4	We	ek 5	We	ek 6	We	ek 7	We	ek 8
Do you consider yourself to be in good general health?	Yes	No														
Do you believe you breathe well throughout most of the day?	Yes	No														
Do you take deep breaths at least 3 times every hour?	Yes	No														
Do you regularly set aside moments in the day to breathe deeply?	Yes	No														
Do you drink at least 3 liters of water per day (or, if you are under 65 kg, 40ml/kg/day)?	Yes	No														
Do you drink water regularly, every hour or at most every 2 hours?	Yes	No														
Are you regularly concerned about the quality of the water you drink?	Yes	No														
Do you follow a "Low Carb" standard diet or Intermittent Fasting, or at least consume fewer carbohydrates and more fats as energy sources?	Yes	No														
Do you try to avoid the consumption of processed, industrial, GMO, and non-organic foods in your daily life?	Yes	No														
Do you avoid consuming artificial sweeteners such as cyclamate, aspartame, saccharin, and sucralose?	Yes	No														
Do you eat a variety of fibers (leafy greens, fruits, vegetables, legumes, sprouts, mushrooms, hearts of palm, seeds, etc.) at least twice a day, every day?	Yes	No														
Do you have nutritional counseling or at least minimally follow a diet prescribed by a nutritionist?	Yes	No														
Do you frequently eat/drink (or indulge in excess at least twice a week) any of these: sweets, cakes, savory snacks, sodas, pasta, sugar, breads, fast food, tapioca, cereals, potatoes, popcorn, etc.?	No	Yes														

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Do you frequently consume gluten, milk (and dairy products), or red	No	Yes														
meat?																
Do you have a bowel movement every day?	Yes	No														
Are your stools most frequently Type 3 or 4 on the Bristol Scale?	Yes	No														
Do you frequently experience gastrointestinal symptoms (heartburn,	No	Yes														
reflux, phlegm, gas, diarrhea, constipation, excessive foul odor in																
stools, malformed stools, feeling too full after eating, etc.)?																
Do you chew your food well before swallowing?	Yes	No														
Do you use vegetable oils (soy, canola, corn, or sunflower) more than	No	Yes														
4 times a week?																
Do you have the habit of drinking tea at least 3 times a week?	Yes	No														
Do you drink more than 6 (small) cups of coffee per day?	No	Yes														
Physical exercise: Do you practice regularly, at least 4 times a week?	Yes	No														
Do you practice "Strength" exercises at least twice a week?	Yes	No														
Do you spend a lot of time sitting during the day? Or standing in the	No	Yes														
same position?																
Do you have difficulty falling asleep and/or wake up often during the	No	Yes														
night?																
Do you wake up rested in the morning, feeling energy/willingness for	Yes	No														
the day?																
Do you maintain stimulating activities or exposure to light until	No	Yes														
bedtime?																
Do you believe you suffer from little or no stress on most of your	Yes	No														
days?																
When you are stressed: do you usually experience very bothersome	No	Yes														
symptoms, worsening of existing symptoms, or difficulty overcoming																
the stress?																

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| Do you get sun exposure regularly, at least 3 times a week? | Yes | No |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Do you know how to expose yourself to the sun properly (and the benefits of this exposure)? | Yes | No |
| Do you smoke or have you smoked regularly in the last 5 years? | No | Yes |
| Do you drink or have you drunk alcohol in excess (or frequently)? | No | Yes |
| Do you think you are regularly subjected to any excess or intoxication? | No | Yes |
| Do you believe you generally have a positive/optimistic attitude towards life? | Yes | No |
| Do you believe you are well mentally and psychologically? | Yes | No |
| Do you regularly display irritability, anxiety, or sadness? | No | Yes |
| Do you engage in leisure, fun, and relaxation activities daily? | Yes | No |
| Do you usually set aside time to identify your goals and plan your days? | Yes | No |
| Do you practice Meditation, Yoga, TaiChi, or something Yesilar regularly? | Yes | No |
| Do you try to maintain frequent contact with nature, at least once a week? | Yes | No |
| Do you maintain a regular relationship with God (or a higher power you believe in)? | Yes | No |
| Do you maintain frequent contact with friends or groups with common interests? | Yes | No |
| Do you keep yourself well-informed and updated on HEALTH topics? | Yes | No |
| Have you had a medical checkup in the last 12 months? | Yes | No |
| Have you had a consultation with a nutritionist in the last 12 months? | Yes | No |
| Have you had a consultation with a dentist in the last 12 months? | Yes | No |

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| Have you had "more complete" exams (including hormones) in the last 12 months? | Yes | No |
|--|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Do you have or have you ever had inadequate weight (overweight, obesity, or underweight)? | No | Yes |
| Do you have or have you ever had a "more serious" illness or one that left a disability? | No | Yes |
| Do you use any medication regularly? | No | Yes |
| Are there serious illnesses in close family members? | No | Yes |
| Do you have an allergy/intolerance to any factor to which you are still exposed? | No | Yes |
| Have you accessed the material at www.icaro.med.br or at least the material at www.icaro.med.br/SAUDE? | Yes | No |
| Have you defined your Ikigai? | Yes | No |
| Do you already practice meditation every day, regularly? | Yes | No |
| Do you already stretch every day, regularly? | Yes | No |
| Have you read the free content at DomineSuaSaude.com.br? | Yes | No |
| Have you watched the detailed class about the book at icaro.med.br/imersão? | Yes | No |

Learn how to use this questionnaire at www.icaro.med.br/QUESTIONARIO

This questionnaire is part of my latest book, available in PDF and print. Check it out!