PHYSICAL HEALTH

Has your doctor told you that you are overweight?	Y/N
Have you been diagnosed with either prediabetes or diabetes?	Y/N
Are you taking *prescription* medication for a chronic disease, such as heart disease, blood pressure, cholesterol, asthma, acid reflux, joint pain, or insomnia?	Y/N
Are you taking *over-the-counter* remedies for acid reflux, pain, allergies, or insomnia?	Y/N
Do you have an irregular menstrual cycle?	Y/N
Do you have hot flashes or disrupted sleep related to menopause?	Y/N
Do you have a decreased libido?	Y/N
Have you been diagnosed with a disease linked to chronic inflammation, such as multiple sclerosis or inflammatory bowel disease?	Y/N
Do you have frequent lower back pain?	Y/N
Have you been diagnosed with sleep apnea?	Y/N
Do you snore?	Y/N
Do you wake up feeling congested or with a stuffy nose?	Y/N
Do you have frequent abdominal pain, heartburn, or indigestion?	Y/N
Do you have frequent headaches or migraines?	Y/N
Do your eyes feel tired at the end of the day?	Y/N

MENTAL HEALTH

Do you feel anxious?	Y/N
Do you feel low or have frequent blue moods?	Y/N
Do you struggle with attention and focus?	Y/N
Do you experience brain fog or poor concentration?	Y/N
Do you frequently lose items, like your glasses, a charging cable, or keys?	Y/N
Are you forgetful of names and faces?	Y/N
Do you rely on a calendar or to-do lists?	Y/N
Do you get tired in the afternoon?	Y/N
Do you wake feeling tired?	Y/N
Have you been diagnosed with post-traumatic stress disorder (PTSD)?	Y/N
Have you been diagnosed with attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), or bipolar disorder?	Y/N
Do you have food cravings?	Y/N
Do you feel like you have a lack of willpower over food?	Y/N
Have you been told that you are irritable?	Y/N
Do you have trouble making decisions?	Y/N

BEHAVIORAL HABITS

Do you take less than 5,000 steps a day?	Y/N
Do you spend less than an hour outdoors under daylight each day?	Y/N
Do you exercise after 9:00 p.m.?	Y/N
Do you spend more than an hour on the computer, your phone, or watching TV before bedtime?	Y/N
Do you have one or more alcoholic drinks (cocktails, wine, or beer) after dinner?	Y/N
Do you forget to drink water throughout the day?	Y/N
Do you drink coffee, tea, or caffeinated soda in the afternoon or evening?	Y/N
Do you consume chocolates, high-carb foods (doughnuts, pizza), or energy drinks to improve your energy level?	Y/N
Do you binge on foods late in the day regardless of hunger?	Y/N
Do you drink or eat anything (other than water) after 7:00 p.m.?	Y/N
Do you sleep with a light on?	Y/N
Do you set aside less than 7 hours for sleep and rest every day?	Y/N
Do you need an alarm clock to wake up in the morning?	Y/N
Do you typically catch up on sleep on the weekends?	Y/N
Do you eat whenever food is presented to you, even if you are not hungry?	Y/N