



Please fill out the digital form, save and email or print out pdf, fill in, scan and email. All of your information will remain confidential between you and the Health Coach.

**PERSONAL INFORMATION**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Email: \_\_\_\_\_ How often do you check email? \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Current weight: \_\_\_\_\_ Weight six months ago: \_\_\_\_\_ One year ago: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

**SOCIAL INFORMATION**

Relationship status: \_\_\_\_\_

Where do you currently live? \_\_\_\_\_

Children: \_\_\_\_\_ Pets: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

**HEALTH INFORMATION**

Please list your main health concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other concerns and/or goals? \_\_\_\_\_

\_\_\_\_\_

At what point in your life did you feel best? \_\_\_\_\_

\_\_\_\_\_

Any serious illnesses/hospitalizations/injuries? \_\_\_\_\_

\_\_\_\_\_



**HEALTH INFORMATION** (continued)

How is/was the health of your mother? \_\_\_\_\_

How is/was the health of your father? \_\_\_\_\_

What is your ancestry? \_\_\_\_\_ What blood type are you? \_\_\_\_\_

How is your sleep? \_\_\_\_\_ How many hours? \_\_\_\_\_ Do you wake up at night? \_\_\_\_\_

Why? \_\_\_\_\_

Any pain, stiffness, or swelling? \_\_\_\_\_

Constipation/Diarrhea/Gas? \_\_\_\_\_

Allergies or sensitivities? Please explain: \_\_\_\_\_

**WOMEN'S HEALTH**

Are your periods regular? \_\_\_\_\_ How many days is your flow? \_\_\_\_\_ How frequent? \_\_\_\_\_

Painful or symptomatic? Please explain: \_\_\_\_\_

Reached or approaching menopause? Please explain: \_\_\_\_\_

Birth control history: \_\_\_\_\_

Do you experience yeast infections or urinary tract infections? Please explain: \_\_\_\_\_

**MEDICAL INFORMATION**

Do you take any supplements or medications? Please list: \_\_\_\_\_

Any healers, helpers, or therapies with which you are involved? Please list: \_\_\_\_\_

What role do sports and exercise play in your life? \_\_\_\_\_



**FOOD INFORMATION**

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your food like these days

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? \_\_\_\_\_

Do you cook? What percentage of your food is home-cooked? \_\_\_\_\_

Where do you get the rest from? \_\_\_\_\_

Do you crave sugar, coffee, cigarettes, or have any major addictions? \_\_\_\_\_

The most important thing I should do to improve my health is: \_\_\_\_\_

**ADDITIONAL COMMENTS**

Anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_