Please write or print clearly. 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? |  |

|  |  |
| --- | --- |
| Best number to reach you: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Age: |  | Height: |  | Date of Birth: |  | 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? |  |

|  |  |
| --- | --- |
| Grandchildren: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Occupation: |  | Hours of work per week: |  |

|  |  |
| --- | --- |
| What is your retirement plan? |  |

HEALTH INFORMATION

|  |  |  |
| --- | --- | --- |
| Please list your main health concerns: | |  |
|  |  | |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Other concerns and/or goals? | |  |
|  |  | |

HEALTH INFORMATION (continued)

|  |  |
| --- | --- |
| At what point in your life did you feel best? |  |

|  |  |  |
| --- | --- | --- |
| Any serious illnesses/hospitalizations/injuries? | |  |
|  |  | |

|  |  |
| --- | --- |
| 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: |  |

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 does exercise play in your life? |  |

|  |  |
| --- | --- |
| What is your energy like? |  |

|  |  |  |
| --- | --- | --- |
| Do you still feel independent? Please explain: | |  |
|  |  | |

|  |  |
| --- | --- |
| Are you part of a community? Please explain: |  |

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 |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
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|  |  |
| --- | --- |
| 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? |  |
|  | |
|  | |
|  | |