Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Age: _____ Height: _____ Sex: _____ Ancestry: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

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

SOCIAL INFORMATION

Relationship status: _____

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? _____

_____

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

Why? _____

HEALTH INFORMATION (continued)

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 physical activity play in your life? _____

_____

FOOD INFORMATION

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 change about my diet to improve my health is: _____

_____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

