**No Excuses! MW, LLC**

# HEALTH & HISTORY FORM

PERSONAL CONTACT INFO

Date:_____

Name:_____

Address:_____

_____

Phone Number:_____Cell Number:_____

Email:_____

On a scale from 1 to 10 with 10 being the BEST, please rate your overall health status today. _____

HEALTH HISTORY

Age:_____Height:_____Date of Birth:_____

Current Weight:_____Weight 6 Months ago:_____Weight 1 Year ago:_____

"Healthiest" weight:_____ And when were you at that weight last?:_____

What would you like your weight to be?:_____

Rate your health- Below Average:_____Average:_____Above Average:_____

Do you take any vitamins/medications and if so, what?:_____

_____

Are you currently involved in an exercise program or other healing modality such as strength training, cardio training, yoga, meditation, acupuncture, massage, etc.?:_____

_____

How often do you participate in physical activity and for what duration?_____

Do you take any stimulants such as cigarettes, coffee, diet pills, alcohol, etc.?:_____

_____

Do you have a family history of heart disease and if so who's side, mother, father or both?:_____

Do you have any siblings, if so, how many?:_____How is their health?:_____

PERSONAL LIFE

Relationship status: M___S___D___Other___ / Children:_____

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WORK LIFE

Occupation:_____

How many hours do you work weekly?:_____

Is your job active or sedentary?:_____

SLEEP PATTERNS

How many hours of uninterrupted sleep do you get?:_____

Do you sleep through the night?:_____

If you wake up, for what?:_____For how long?:_____And what time?:_____

What time do you get up in the morning?:_____

YOUR FOCUS

What are your main health concerns?:_____

_____

What are your expectations from this counseling session?:_____

_____

EATING HABITS

Are you eating from the 5 major food groups daily (Grains, veggies, fruit, dairy, meat)?_____

How many meals do you eat at home per week?:_____

How many of those meals are “homemade” (not frozen or take out)?:_____

How many times do you dine out?:_____

What is your favorite restaurant?:_____

What is your favorite meal?:_____

Do you snack and if so, what do you snack on?:_____

How many ounces of water do you drink a day?:_____

What are your struggles when it comes to proper nutrition?:_____

_____

Please list any other questions, concerns, or comments that you would like to discuss:_____

_____