# MEN'S KICKSTART CONSULTATION FORM

*Please write or print clearly. All of your information will remain confidential between you and the health coach.*

## Personal Information

Full Name _____ Email _____

Best Phone _____ How often do you check your email? _____

Age _____ Height _____ DOB _____ Place of Birth _____

Current Weight _____ Weight 6 Months Ago _____ Weight 1 Year Ago _____

## Social Information

Relationship Status _____ Where do you currently live? _____

Children _____ Pets _____

Occupation _____ Hours of work each week _____

## Health Information

Please list all main health concerns. _____

_____

Other concerns and goals. _____

_____

When did you last feel your best? _____

Hospitalizations or injuries? _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____ Blood Type? _____

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

Why? _____

Pain, stiffness or swelling? _____

Diarrhea/Constipation/Gas _____

Allergies or sensitivities? Explain. _____

## *Medical Information*

Do you take any supplements or medications? Please list. _____

_____

Are you involved with other healers, helpers or therapies? Please list. _____

_____

What role do sports or exercise play in your life? _____

## *Diet Information*

What foods did you eat the most as a child?

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

What foods do you eat the most now?

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you cook? _____ How often? _____ Where do you get food from? _____

Do you crave sugar, salt, coffee, cigarettes or have any major addictions? _____

What do you want to improve most? _____

Who will support you in this journey? _____

Anything else you'd like to share? _____