

WOMEN'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 Month Ago	ns		Weight 1 Year Ago		
Social Informati Relationship Status	on		Where c	do you ly live?		
Children —						
Occupation				urs of work ch week		
When did you last f	feel your best?					
Hospitalizations or	injuries?					
How is/was the hea	alth of your mother?					
How is/was the hea	alth of your father?					
-	try?	How many_ hours?		Blood Type? Do you wake up at night?		
Why?						
Pain, stiffness or sw	velling?					
Diarrhea/Constipat	ion/Gas					
Allergies or sensitiv	vities? Explain					

Women's Health			How from top+2				
Do you have regular		How many days is your	———	How frequent?			
periods?		flow?					
Painful or symptoma Please explain. ——							
Reached or approach		??					
Birth control history							
Yeast infection or uri infections? Please exp							
Medical Informatio							
Do you take any supposed medications? Please							
Are you involved with helpers or therapies?							
What role do sports of exercise play in your							
Diet Information What foods did you	eat the most as a	child?					
Breakfast	Lunch	Dinner	Snacks	Liquids			
What foods do you e	<u> </u>						
Breakfast	Lunch	Dinner	Snacks	Liquids			
l Do you cook?	How d	How often? Where do you					
Do you crave sugar, s	alt, coffee, cigaret	tes or have any major ad	get food from? dictions?				
What do you want to	improve most?						
Who will support you	in this journey?						
Anything else you'd l	ike to share?						