

Health Coach Intake Form

First Name _____ Last Name _____ Date _____

Phone Number _____ Email _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthday _____

Emergency Contacts

Full Name _____ Relationship _____ Phone Number _____

Full Name _____ Relationship _____ Phone Number _____

Health and Medical Information

Primary Care Physician _____ Phone Number _____

Address _____

Primary Therapist _____ Phone Number _____

Address _____

Current conditions, illnesses/ hospitalization injuries?

Medical information

Do you use alcohol or drugs daily? _____

Do you smoke or use tobacco products? _____

Which drugs (not prescribed medications) have you used in the last 10 years?

Do you take any supplements or medications?

Social Information

Relationship statue_____

Children _____ Pets _____

Occupation _____ Hours of work per week? _____

Health Information

Main health concern(s)?

Other concerns and/or goals?

At what point in your life did you feel best?

Health Information (Continue)

How is/was the health of your mother? _____

How is/was the health of your father? _____

How is your sleep? _____ How many hours? _____

Do you wake up at night? _____ Why?_____

What role do sports and exercise play in your life?

Any pain or stiffness, or swelling? _____

Constipation/Diarrhea /Gas? _____

Food Information

What foods did you eat often as a child?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

What foods do you eat now?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

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? _____

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?
