Wellness Coaching Intake Form

Please complete this form to help us understand your health history, lifestyle, and wellness goals. Your responses are confidential and will guide your personalized coaching journey.

Personal Information

Full Name *

First Name Last Name

Email Address *

example@example.com

Phone Number

Please enter a valid phone number.

Date of Birth *

Month Day Year

Medical History

Do you have any current or past medical conditions?

Are you currently taking any medications or supplements? Please list them.

Have you had any surgeries or hospitalizations?

Do you have any allergies?

Lifestyle Habits

How would you describe your nutrition and eating habits?

How many days per week do you engage in physical activity?

What types of movement or exercise do you enjoy?

How many hours of sleep do you typically get per night?

How would you rate your sleep quality?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

How do you typically manage stress?

On a scale of 1-10, how would you rate your current stress level?

	1	2	3	4	5	6	7	8	9	10	
Low	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	High

Menstrual & Reproductive Health

Are you currently menstruating?

- ◯ Yes
- ◯ No
- ◯ Pregnant

- ◯ Post-menopausal
- ◯ Other

Do you experience any menstrual irregularities, discomfort, or other reproductive health concerns?

Are you currently using any form of contraception or fertility support?

Mental & Emotional Wellbeing

How would you describe your overall mood and emotional wellbeing?

Do you have a support system (family, friends, community)?

- ◯ Yes
- ◯ No
- ◯ Somewhat

Are you currently receiving counseling, therapy, or other mental health support?

- ◯ Yes
- ◯ No

Do you have any concerns related to anxiety, depression, or other mental health conditions?

Wellness Goals

What are your short-term wellness goals (next 3-6 months)?

What are your long-term wellness goals (next 1-5 years)?