



**Senior**

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

**Personal**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Email: \_\_\_\_\_

How often do you check your email? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Weight 6 Months Ago: \_\_\_\_\_ Weight One Year

Ago: \_\_\_\_\_

Would you like your weight to be different?    Y   N    If so, how? \_\_\_\_\_

**Social**

Relationship Status: \_\_\_\_\_

Where do you live? \_\_\_\_\_

Any Children? \_\_\_\_\_ Grandchildren? \_\_\_\_\_

Occupation: \_\_\_\_\_ How many hours do you work per week? \_\_\_\_\_

What is your retirement plan? \_\_\_\_\_

**General Health**

What are your main health concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other concerns and or goals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

At what point in your life did you feel your best? \_\_\_\_\_

Any current or previous serious illnesses, hospitalizations, or injuries? \_\_\_\_\_

\_\_\_\_\_

How is/was your mother's health? \_\_\_\_\_



\_\_\_\_\_ **Senior**

**General Health (Continued)**

How is/was your father's health? \_\_\_\_\_

What is your ancestry? \_\_\_\_\_ Blood Type? \_\_\_\_\_

How is your sleep? \_\_\_\_\_ How many hours do you sleep per night? \_\_\_\_\_

Do you wake up during the night? Y N If so, why? \_\_\_\_\_

\_\_\_\_\_

Any pain, stiffness, or swelling? \_\_\_\_\_

Any constipation, diarrhea, or gas? \_\_\_\_\_

Any allergies or sensitivities? \_\_\_\_\_

**Medical**

List all supplements or medications: \_\_\_\_\_

\_\_\_\_\_

Are you involved with any healers, helpers, or therapies? \_\_\_\_\_

\_\_\_\_\_

What role does exercise play in your life? \_\_\_\_\_

\_\_\_\_\_

What is your energy like? \_\_\_\_\_

Do you still feel independent? Explain: \_\_\_\_\_

\_\_\_\_\_

Are you part of a community? Please explain: \_\_\_\_\_

**Food**

Will your family and friends be supportive of you making food and/or lifestyle changes? Y N

Do you cook? Y N What percentage of your food is home-cooked? \_\_\_\_\_

Where does the non-home-cooked food come from? \_\_\_\_\_



**Senior**

**Food (Continued)**

What foods do you often eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you crave sugar, coffee, or cigarettes? Do you have any other major addictions? \_\_\_\_\_

What is the most important thing you should change about your diet to improve your health? \_\_\_\_\_

**Additional Comments**

Is there anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_