CONSULTATION FORM

Date:_____

Personal Information

Name:_____

Phone Number:_____

Email Address:_____

Home Address:_____

Emergency Contact Name & Phone #:_____

Age:_____

Weight:_____

Height:_____

Marital Status:_____

Children:_____

Occupation:_____

Extra-Curricular Activities:_____

Rate your daily activity level on a scale of 1-5 (1 being sedentary, 5 being extremely active):_____

What are the main reasons you are interested in our services?_____

_____

How did you hear about us?_____

If it was easy, everyone would be doing it!

Health, Medical, & Lifestyle Section

(**Females Only**) Are you or could you be pregnant?_____Are you breastfeeding?_____

Perimenopausal or menopausal?_____ If yes, what are your symptoms?_____

Last check up at the doctor:_____Any medical concerns/injuries we should be made aware of?_____

_____

Family & Medical History - Circle any that apply to you specifically or your immediate family.

Heart Disease	High/Low Blood Sugar	Diabetes	High Blood Pressure	Stroke	Arthritis/Joint Pain
High Cholesterol	Asthma	Cancer	Depression	Anxiety	Allergies

Do you smoke (cigarettes or cannabis)? How often?_____

Are you taking any medication or supplements?_____If yes, please list:_____

Gut Health: Bowel movement frequency:_____Frequent constipation and/or diarrhea?_____

Do you experience the following: Bloating:_____Indigestion:_____Cramping:_____Gas:_____

Rate your sleep quality on a scale of 1-10 (10 being excellent):_____

How many hours of sleep do you get on average?_____Do you experience difficulty sleeping?_____

If so, please describe:_____

Rate your overall day to day energy levels on a scale of 1-10 (10 being very energetic):_____

Please explain:_____

Rate your daily stress level on a scale of 1-10 (10 being very stressed)_____

What are your stressors?_____How do you cope with stress?_____

What does your typical weekly schedule look like? (work, commitments, etc.)_____

_____

Do you have the support from your family & friends in relation to your health goals?_____

Additional Notes:_____

_____

_____

Nutrition & Goals

What are your top health goals currently and why? (i.e.: lose weight, increase energy, decrease stress, etc.)

_____

How important are your health goals to you and why? (scale 1 – 10)_____

Food allergies or sensitivities:_____

What are you looking to change/improve about your current eating habits? Please list:_____

_____

Food preferences – list favorite foods, dishes, meals, food groups, etc.:_____

_____

Food dislikes – please list:_____

How would you rate your current nutrition habits (scale 1 – 10)_____

How many times a day do you eat on average?_____

How often do you consume the following?

Restaurant/fast food:_____Alcohol:_____Snack foods:_____High calorie beverages:_____

Processed food:_____Coffee:_____Water:_____Fruits:_____Veggies:_____

What are the main barriers currently that prevent you from eating healthy (i.e.: time, lack of knowledge, stress)?_____

What are you hoping Infinity services might do to help you with nutrition?_____

Discuss food log if applicable (nutritional analysis and quick tips)

Additional Notes:_____

_____

_____

Exercise History

Are you currently exercising? Please describe:_____

_____

If no, have you before? Why did you stop, and how long ago?_____

Are there any barriers preventing you from exercising regularly (i.e.: motivation, not seeing results, time management):_____

What are you hoping Infinity services might do to help you to help you with fitness?_____

_____

Additional Notes:_____

_____

Is there any other information relevant to your overall health and wellbeing that you would care to share?

I, _____, acknowledge that the above information is accurate, and herby authorize Infinity Nutrition and Health Coaching to use my personal information to better assist my health and wellness needs.

Signature: Date:

Cost of consultation: Method of Payment:

Consultation done by: Location (East or West):

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