CLIENT INTAKE

Let's Get Started

Name:

Date of Birth:

Phone number:

Email address:

Height:

Weight:

Occupation:

Place of Residence:

Past medical history:

What is your primary reason for seeking coaching at this time?

Have you had any previous coaching or treatment before?

What medications or supplements are you currently taking?

CLIENT INTAKE CONT.

Do you experience any of the following symptoms?

- ☐ Headaches
- ☐ Joint pain
- ☐ Gastrointestinal issues
- ☐ Difficulty sleeping
- ☐ Anxiety/depression
- ☐ Cardiac issues
- ☐ Difficulty gaining weight
- ☐ Difficulty losing weight
- ☐ Fatigue
- ☐ Skin issues
- ☐ Balance issues
- ☐ Frequent infections

Who do you live with and are they supportive of your health journey? Are their others who can help hold you accountable?

Do you enjoy cooking? Do you enjoy exercise:

Is there anything you are not willing to try at this time? Examples are foods you won't eat, strategies you've tried in the past that did not work for you, etc.

What are your top goals for this program?

Any additional comments for your coach: