

Instructions:

Option A: Type directly into the fields and be sure to save your work along the way. When finished, save and send the form to: [lmcdonald@nyc.rr.com](mailto:lmcdonald@nyc.rr.com)

Option B: Print and fill out neatly by hand, scan and resend or submit in person.

All of your information will remain confidential between you and the Health Coach

**PERSONAL INFORMATION**

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

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

Email: \_\_\_\_\_ How often do you check email? \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

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

Current weight: \_\_\_\_\_ Weight six months ago: \_\_\_\_\_ One year ago: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

**SOCIAL INFORMATION**

Relationship status: \_\_\_\_\_

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

Children: \_\_\_\_\_ Pets: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_



## Health History

---

### HEALTH INFORMATION

Please list your main health concerns: \_\_\_\_\_

\_\_\_\_\_

Other concerns and/or goals? \_\_\_\_\_

\_\_\_\_\_

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

Any serious illnesses/hospitalizations/injuries? \_\_\_\_\_

\_\_\_\_\_

How is/was the health of your mother? \_\_\_\_\_

How is/was the health of your father? \_\_\_\_\_

What is your ancestry? \_\_\_\_\_ What blood type are you? \_\_\_\_\_

How is your sleep? \_\_\_\_\_ How many hours? \_\_\_\_\_ Do you wake up at night? \_\_\_\_\_

Why? \_\_\_\_\_

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

Constipation/Diarrhea/Gas? \_\_\_\_\_

Allergies or sensitivities? Please explain: \_\_\_\_\_



## Health History

### MEDICAL INFORMATION

Do you take any supplements or medications? Please list: \_\_\_\_\_

\_\_\_\_\_

Any healers, helpers, or therapies with which you are involved? Please list: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

### FOOD INFORMATION

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



## Health History

---

### **FOOD INFORMATION** (Continued)

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 from? \_\_\_\_\_

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

\_\_\_\_\_

The most important thing I should change about my diet to improve my health is: \_\_\_\_\_

\_\_\_\_\_

### **ADDITIONAL COMMENTS**

Anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_