

Men's Health History Form

Please write or print clearly. All of your information will remain confidential between you and the Health Coach. Feel free to ask your health coach any questions you may have regarding this form.

Personal Information

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Age: _____ Date of Health History: _____

Phone: Mobile: _____ Work: _____ Home: _____

Email: _____ Preferred Contact Method: _____

Height: _____ Current Weight: _____ Wt. 6 months ago: _____ 1yr ago: _____

Would you like your weight to be different? How? _____

Social Information

Relationship Status: _____

Where do you currently live? _____

of Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Health Information

Please list your main health concerns: _____

Other goals? _____

At what point in your life did you feel your best? _____

Any serious illnesses/ hospitalizations/ injuries? _____

How was/is your mother's health? _____

How was/is your father's health? _____

What is your blood type? _____. How is your sleep? _____

How many hours do you get each night? _____ Do you wake up at night? _____

If yes, why? _____

Any pain, stiffness or swelling? _____

Any digestive problems (constipation, diarrhea, gas, etc.)? _____

Allergies or sensitivities? Please explain: _____

Do you have any diagnosed medical conditions? _____

Please list any medications or supplements you are taking: _____

Are there any other therapies or treatments that you are involved in? Please list: _____

How often do you exercise: _____ Never _____ 1-3x/month _____ 1-2x/week _____ 3-5x/week

Do you smoke? _____ Often _____ Sometimes _____ Never

Do you drink alcohol? _____ Often _____ Sometimes _____ Never

Do you eat fast food? _____ Often _____ Sometimes _____ Never

How often do you eat away from home? _____ Often _____ Sometimes _____ Never

Food Information

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 is the rest of your food from? _____

Do you have a specific concern(s) related to your diet/ nutrition? _____

Do you crave foods such as sugar, coffee, cigarettes, or have any major addictions? _____

The most important thing I should do to improve my health is: _____

What would you like to gain from working with a health coach? _____
