Health Coaching Intake

PATIENT INFO

First Name ____________ MI ______ Last ____________ Birth Date ____ / ____ / ____

Address ____________ City ____________ State ______ Zip ______

Home # ____________ Cell # ____________ Email ____________

Can we send you occasional text messages for important reminders? Yes ______ No ______

Preferred Contact Method ____________ Occupation ____________

# of Hours of work per week ____________ Gender ____________ # of children ______

Pets ____________ Single Married Widowed Divorced Partnered

Who may we thank for referring you to our office? ____________

TELL ME ABOUT YOUR HEALTH

Please list your main health concern(s): ____________

Do you have any non-health-related goals you'd like to reach? ____________

Height: ______ Current Weight: ______ Wt. 6 months ago: ______ Wt. 1 year ago: ______

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

Any serious illnesses/ hospitalizations/ injuries? ____________

How is the health of your parents? ____________

Any pain, stiffness or swelling? If yes, please explain: ____________

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

Any allergies or sensitivities? If yes, 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 you are involved in? If yes, please list (ex: chiropractic, mental health, PT, etc.): ____________

WOMEN ONLY

Are your periods regular? ____________ How long is your cycle? ____________

Are your periods painful or symptomatic? If yes, please explain: ____________

Birth control history: ____________

Do you experience yeast infections or urinary tract infections? ____________

FOR OFFICE USE ONLY:

PATIENT NUMBER: ______

LIFESTYLE FACTORS & ADDITIONAL INFORMATION

Please rate your satisfaction with each of the following areas:
(1- Very Dissatisfied 10- Very satisfied)

Sleep	1	2	3	4	5	6	7	8	9	10
Energy	1	2	3	4	5	6	7	8	9	10
Relationships	1	2	3	4	5	6	7	8	9	10
Mood	1	2	3	4	5	6	7	8	9	10
Healthy Eating	1	2	3	4	5	6	7	8	9	10

Sleep

How many hours of sleep do you get each night?__________ Do you wake up at night?________________________________

If yes, why?____

Do you wake in the morning feeling well-rested?____

Energy

How often do you exercise? _____Never _____1-3x/month _____1-2x/week _____3-5x/week

Relationships / Mood

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?______________________

Describe your support system:____

____

What helps keep you accountable?____

____

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

____

Healthy Eating

Do you cook?______________________________ What percentage of your food is home cooked/ prepared?__________

Where is the rest of your food from?____

How often do you drink alcohol? _____Never _____1-3x/month _____1-2x/week _____3-5x/week

How often do you eat fast food? _____Never _____1-3x/month _____1-2x/week _____3-5x/week

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

Do you crave foods such as sugar, coffee or have any other addictions?_________________________________

What foods did you eat often as a child?

Breakfast	Lunch	Dinner
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Help me, help you!

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

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