Feed Your Heart and Soul

Nutrition Health Coaching for Body Mind & Spirit

Health History Form

name Date

Get Started Right Away

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

PERSONAL

Name: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____How often do you check your email? _____

Date of Birth: _____ Place of Birth: _____Age: _____

Height: _____weight _____ Weight Six Months Ago: _____ Weight One Year Ago: _____

Would you like your weight to be different? _____ If so, how?_____

SOCIAL

Relationship Status: _____

Where do you live? _____

Any children? _____ Any pets? _____

Occupation: _____ How many hours do you work per week? _____

GENERAL HEALTH

What are your main health concerns? _____

_____

_____

Any other concerns and/or goals? _____

_____

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At what point in your life did you feel your best? _____
Any current or previous serious illnesses, hospitalizations, or injuries? _____

How is/was your mother's health? _____

How is/was your father's health? _____

What is your ancestry? _____ What is your blood type? _____

Do you have family history of any diseases or trauma? _____

GENERAL HEALTH (continued)

How is your sleep? _____ How many hours do you sleep per night? _____

Do you wake up during the night? If so, why? _____

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

MEDICAL

List all supplements or medications (add more at end of form if needed)_____

Are you involved with any healers, helpers, or therapies? _____

What role do sports and exercise play in your life? _____

FOOD

Will your family and 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 does your non-home-cooked food come from? _____
What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

FOOD (continued)

Do you crave sugar, coffee, or cigarettes? Do you have any other major addictions? _____

_____

What is the most important thing you should change about your diet to improve your health? _____

_____

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____

_____

ADDITIONAL COMMENTS (if applicable) WOMEN'S HEALTH

Are your periods regular? _____

How many days are your flow? _____

How frequent _____

Are your periods painful or symptomatic _____

If so, please explain? _____

What is your birth control history? _____

Are you approaching menopause? _____

Do you experience yeast symptoms or UTIs _____

If yes to any above, please explain: _____

ADDITIONAL COMMENTS (if applicable) TEEN'S HEALTH

Do you enjoy school?_____

Are you concerned with Body image? _____

What is your age?: _what are your career goals?: _____

Do you participate in organized sports _____

Do you have a small or large group of friends? _____

ADDITIONAL COMMENTS (if applicable) SENIOR'S

What are your retirement plans? _____

Do you live in community? _____