Welcome! I look forward to working with you. Please fill out the Health Discovery form and email me before your first session. All information will remain confidential between you and your 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? |  |

|  |  |
| --- | --- |
| Why did you come for a Health History? |  |

SOCIAL INFORMATION

|  |  |
| --- | --- |
| What is your relationship status? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What grade are you in? |   | Do you enjoy school? Please explain: |  |
|  |  |

|  |  |
| --- | --- |
| Do you have a large or small group of friends? |   |

HEALTH INFORMATION

|  |  |
| --- | --- |
| Please list your main health concerns: |   |
|  |  |

|  |  |
| --- | --- |
| Other concerns? |  |

|  |  |
| --- | --- |
| Any serious illnesses/hospitalizations/injuries? |  |
|  |  |

|  |  |
| --- | --- |
| How is/was the health of your mother? |  |

|  |  |
| --- | --- |
| How is/was the health of your father? |  |

|  |  |
| --- | --- |
| Where do your parents and grandparents come from? |  |

HEALTH INFORMATION (continued)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How is your sleep? |  |  How many hours? |  | Do you wake up at night? |  |

|  |  |
| --- | --- |
| Why? |  |

|  |  |
| --- | --- |
| Constipation/Diarrhea/Gas? |  |

|  |  |
| --- | --- |
| Allergies or sensitivities? Please explain: |  |

FEMALE TEEN HEALTH

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are your periods regular? |  | How many days is your flow? |  | How frequent? |  |

|  |  |
| --- | --- |
| Painful or symptomatic? Please explain: |  |

|  |  |
| --- | --- |
| What is your birth control history? |  |

|  |  |
| --- | --- |
| Do you experience yeast infections or urinary tract infections? Please explain: |  |

MEDICAL INFORMATION

|  |  |
| --- | --- |
| Are you concerned with body image? Please explain: |   |
|  |  |

|  |  |
| --- | --- |
| Do you take any supplements or medications? Please list: |  |

|  |  |
| --- | --- |
| Do you have any healers, helpers, therapies, or pets? Please list:  |  |
|  |  |

|  |  |
| --- | --- |
| What role does exercise, sports, and activities play in your life? |  |
|  |  |

FOOD INFORMATION

|  |
| --- |
| What foods did you eat often as a child?  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

FOOD INFORMATION (continued)

|  |
| --- |
| 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? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What percentage of your food is home-cooked? |  | Do you enjoy the food? |  |

|  |  |
| --- | --- |
| Where do you get the rest from? |  |

|  |  |
| --- | --- |
| Do you crave sugar, coffee, cigarettes, or drugs? Please explain? |  |
|  |  |

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

ADDITIONAL INFORMATION

|  |  |
| --- | --- |
| Anything else you would like to share? |  |
|  |  |
|  |  |
|  |  |