

Basic Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____

Occupation: _____

D.O.B.: _____

Gender: _____ Height: _____ Weight: _____

Support System (circle one) Family Friend Other _____

Billing Information

Credit Card (circle one)

American Express Discover Card Master Card Visa

Credit Card Number _____ Exp. Date _____

Security Code: _____

1. Client Consent

By signing this consent, you are agreeing to the stipulations and requirements of **Health Coaching** mentioned below.

Please read the information carefully, print your name in the blank provided, sign and date it.

I, _____, agree to participate in my Health Coaching Program for the agreed-upon fee. I understand that nutritional supplements will be recommended as part of the Program and that the cost of these supplements is in addition to the Program fee. Additional diagnostic tests (blood, hair, urine analysis) may be required at my expense. I understand that a scheduled session must be cancelled at least 24 hours prior to the session. If I fail to do so, I forfeit the session. I am also aware that a different Coach can be assigned to work with me at any time if necessary. Finally, I agree to read and complete all the forms and provide them to my Coach prior to Session 1. I agree to attend scheduled phone appointments with my Coach and comply with my individualized components designed to assist in the achievement of my fitness goals.

Client Signature or guardian if under 18

Date

2. Physical Activity Readiness

Read each question carefully and answer YES or NO.

For questions 8 and 9; Please initial in the space provided indicating that you understand the recommendation.

YES / NO

1. Has a doctor ever diagnosed a heart condition or recommended only medically supervised physical activity? _____
2. Do you experience chest pain brought on by physical activity? _____
3. Do you tend to fall over or lose consciousness as a result of dizziness? _____
4. Has a doctor ever recommended blood pressure medication or any type of medication for a heart condition? _____
5. Do you have bone or joint problems that could be aggravated by the purposed physical activity? _____
6. Are you aware, through your own experience or doctor's advice, of any physical reason against exercising without medical supervision? _____
7. Are you over the age of 65 and not accustomed to vigorous exercise? _____

If you answered YES to one or more of the questions above,

Please answer and initial the following questions:

8. Have you ever consulted a physician regarding increasing your physical activity and/or performing a fitness assessment? _____
9. If you answered NO to question 8, will you consult a physician prior to increasing your physical activity and/or performing a fitness assessment? _____

3. Health History

Check all conditions that apply and list any medications that you currently take for the condition (if applicable).

- ☐ 1. High Blood Pressure
- ☐ 2. Heart Disease or Stroke
- ☐ 3. Neuromuscular Disease
- ☐ 4. Cancer
- ☐ 5. Lung/Pulmonary Disease
- ☐ 6. Kidney Disorder
- ☐ 7. Anemia
- ☐ 8. Ulcer
- ☐ 9. Gallbladder Disease
- ☐ 10. Diarrhea
- ☐ 11. Constipation
- ☐ 12. Diabetes Mellitus
- ☐ 13. Obesity
- ☐ 14. Arthritis
- ☐ 15. Osteoporosis
- ☐ 16. Food Allergies
- ☐ 17. High Triglycerides
- ☐ 18. Arteriosclerosis
- ☐ 19. Gastrointestinal Disease
- ☐ 20. Pregnant/Breast Feeding
- ☐ 21. Special Diet
- ☐ 22. Anorexia
- ☐ 23. Bulimia
- ☐ 24. Compulsive Overeating
- ☐ 25. Depression
- ☐ 26. Recommended High Level Care
- ☐ 27. Monitored by Physician
- ☐ 28. Allergies to Medication
- ☐ 29. Psychological Problems
- ☐ 30. Other Medical Conditions

4. Lifestyle

Please answer each question accurately.

1. What is your primary goal? _____

2. Have you ever participated in weight loss/gain program? (circle one) Yes / No
Which one _____
3. Did you get results? Yes / No
4. Do you exercise? Yes / No
If so, how often? _____
5. What kind of heating system is in your home?
Forced hot air _____ Baseboard _____ Radiant _____ Other _____
6. What kind of flooring is in your home?
Wall to wall carpet _____ Hardwood _____ Area rugs _____ Tile _____
7. What kind of flooring is in your bedroom?
Wall to wall carpet _____ Hardwood _____ Area rugs _____ Tile _____
8. How old is your mattress? _____
9. Do you have any allergies? _____

10. Do you have pets? Yes / No If so, how many? _____
11. Do you drink coffee? _____
How much daily? _____
12. List all medications and dosage you are taking: _____

13. What is your daily water intake? _____
14. How many hours per night do you sleep? _____
15. Do you wake up rested? Yes / No

Health Coaching Intake Form

16. Do you get flu shots yearly? Yes / No
17. Were you vaccinated as a child? Yes / No
18. What brand of deodorant do you use? _____
19. What brand of laundry detergent do you use? _____
20. Is there a water filter in place on your homes water supply? Yes / No
21. Do you live near power lines? Yes / No If yes how close _____
22. Do you or have you lived near any manufacturing facilities? Yes / No
23. Have you ever had lead paint in your home? Yes / No
21. List all the supplements that you are taking in amounts and by which manufacturer.

5. Food Profile

Respond to the following statements *intuitively* rather than *intellectually*.
For example, if you like red meat or feel good after eating it but don't eat it because you think it's bad for you, you should indicate that you like red meat and therefore answer 1 = always/very often.

Your answer should reflect your initial, spontaneous reaction to the statement.

Please respond with the following choices:

1 = ALWAYS / VERY OFTEN

2 = SOMETIMES

3 = RARELY / NEVER

1. _____ When my energy is low, I can increase it by eating something sweet such as fruit, pastry or candy and this feeling lasts.
2. _____ I could enjoy eating potatoes or white rice 2 or 3 times/day.
3. _____ I could eat red meat daily, and often more than once/day.
4. _____ Salads and raw vegetables agree with me and I eat them often.
5. _____ I prefer fatty cuts of meat (ribs, prime rib, roast pork) over very lean meat.
6. _____ I may drag through the day but a high-protein dinner consisting of meat will make me feel better.
7. _____ If I don't feel hungry and eat something sweet, my appetite increases.
8. _____ Steak for breakfast sounds good.
9. _____ I get hungry between meals and like to have a snack.
10. _____ For lunch, I could often eat a BLT or a club sandwich.
11. _____ I could eat lettuce, cottage cheese and fruit salad for lunch.
12. _____ I often crave sweets.
13. _____ I feel better if I have eggs and bacon, or other kinds of meat for breakfast.
14. _____ I can easily skip breakfast without getting hungry or tired.
15. _____ Toast and coffee are all I need for breakfast.
16. _____ I like plain yogurt.
17. _____ A large steak dinner is my idea of a real meal.
18. _____ After a big meat dish, I could eat dessert.
19. _____ Cereal, low-fat yogurt, or fruit for breakfast leaves me hungry shortly thereafter.
20. _____ Meals that contain meat make me tired and sluggish.
21. _____ Meat sits like a rock in my stomach.
22. _____ Between meals, I get so hungry that I need something sweet.
23. _____ I like the taste of olive oil.
24. _____ Drinking coffee makes me jittery.
25. _____ I like bacon.
26. _____ I like the taste of avocado.
27. _____ I experience feelings of low blood sugar (fatigue, weakness, light-headedness).
28. _____ I am hungry even after a regular meal.

HEALTH COACHING INTAKE FORM

29. _____ Sweet foods like candy or cake taste too sweet.
30. _____ I like butter on my potatoes or steak.
31. _____ Sweet things taste sweet enough.
32. _____ I feel a bit weak if I haven't eaten for 2 to 3 hours.
33. _____ I get irritable if I skip a meal.
34. _____ I would like lambs chops for dinner.
35. _____ I have sudden mid-morning or mid-afternoon drop in my energy level.
36. _____ I enjoy drinking orange or grapefruit juice.
37. _____ Even after a big dinner, I get hungry late in the evening or in the middle of the night.
38. _____ Meals composed of mostly vegetables and starches leave me satisfied until the next meal.
39. _____ I'm usually slow about getting started in the morning.
40. _____ I enjoy getting up early in the morning.
41. _____ Rather than 3 large meals/day, I prefer to eat small quantities of food, often.
42. _____ I have a tendency toward constipation.
43. _____ I would rather watch TV than pursue active and/or stimulating recreation.
44. _____ I like pancakes or fruit for breakfast, rather than ham and eggs.
45. _____ I prefer skim or low-fat milk, rather than whole milk.
46. _____ I have 1 or more bowel movements every day.
47. _____ I must eat at least 3 times/day.
48. _____ Cooked vegetables with cheese and rice are a satisfying main course.
49. _____ I have trouble falling asleep at bedtime?
50. _____ I enjoy doing a lot of exercise.
51. _____ When I'm thirsty, I prefer drinking water, rather than juice or a carbonated drink.
52. _____ I tend to be nervous and high-strung.
53. _____ I tend to crave and overeat foods high in fat.
54. _____ I tend to crave and overeat sweet foods and other carbohydrates.
55. _____ I'm tired in the morning, even after 7-8 hours of sleep.

56. _____ On a daily basis, I consume _____ servings of dairy products.
(cheese, ice cream, milk, yogurt, etc.)
1 = Less than 1 2 = 2-3 3 = 3 or more

57. _____ How many times have I lost and regained more than 20 pounds?
1 = Less than 1 2 = 2-3 3 = 3 or more

For Women

58. _____ I become very irritable and nervous the week before my monthly cycle.
59. _____ Regarding #49, the symptoms are: 1-severe 2-moderate 3-mild
60. _____ At present, I am pregnant, lactating, or trying to conceive? Yes / No

6. 5 Day Food Intake

Please list all food and drink that you consume on a *typical day*.

Start from the first item in the morning and list *everything* consumed over the next 24 hours.

For the purpose of this list, a "meal" is any portion of food consumed at any time,

Whether it be a single banana or a seven-course meal.

It is very important to be honest when recording your food and drink intake.

This will help your Coach effectively design your meal plan.

Time / Food or Drink / Portion (oz, cups, etc) / Preparation (fried, grilled, raw, sautéed, etc)

1

2

3

4

5

6

7

8

9

10

Goals:

List in order of your highest priority:

Career

Fame

Family

Health

Wealth

1.

2.

3.

4.

5.
