Health Coaching Questionnaire

Name:______________________________ Date of birth:_______________________ Date:________________________________

Age:________________________________ Height:_____________________________ Zip code:____________________________

Address:____________________________ City:_______________________________ State:_______________________________

Phone:______________________________ Email:____

Occupation:____

List current health problems for which you are being treated:____

____

____

Current medications (prescription or over-the-counter):____

____

____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of your stress:____

____

Do you consider yourself: underweight overweight just right Your weight today:__________________

Do you experience any of these general symptoms EVERY DAY?

Insomnia	Headaches	Inflammation	Fecal incontinence	Discharge
Vomiting	Depression	Low grade fever	Urinary incontinence	Others:________
Nausea	Itching/rash	Disinterest in sex	Disinterest in eating	______________
Diarrhea	Constipation	Debilitating fatigue	Shortness of breath	______________
Bleeding	Dizziness	Chronic pain	Panic attacks	______________

Medical History:

Gout	Pneumonia	Dental Problems	Blood pressure problems
Ulcer	Emphysema	Food intolerance	Irritable bowel syndrome
Colitis	Tuberculosis	Infection, chronic	Chronic fatigue syndrome
Stroke	Osteoporosis	Mental retardation	Kidney or Bladder disease
Cancer	Heart disease	Allergies/hay fever	Seasonal affective disorder
Asthma	Fibromyalgia	Alzheimer's disease	Environmental sensitivities
Obesity	Mental illness	Diverticular disease	Inflammatory bowel disease
Epilepsy	Varicose veins	Migraine headaches	Sexually transmitted disease
Diabetes	Skin problems	Learning disabilities	Gastro-esophageal reflux disease
Arthritis	Drug Addiction	Cholesterol, elevated	Liver or gallbladder disease (stones)
Glaucoma	Sinus problems	Autoimmune disease	Eyes, ears, nose and throat problems
Bronchitis	Thyroid trouble	Circulatory problems	Neurological problems (Parkinson's paralysis)
Alcoholism	Eating Disorder	Urinary tract infection	Other:_______________________________
Depression	Genetic disorder	Carpal tunnel syndrome	____________________________________

Health Coaching Questionnaire Continued

Health Habits:

Tobacco:
Cigarettes: ____/ day
Cigars: ____/day
Alcohol:
Wine: ______ glasses/wk
Liquor: _____ounces/wk
Beer: ______ glasses/wk
Caffeine:
Coffee: ______6 oz cups/d
Tea: _____ 6 oz cups/d
Soda w/ caffeine: _____ cans/d
Other sources:
Water: ______ glasses/d
Others:________________

Exercise:

5-7 days per week
3-4 days per week
1-2 days per week
45 minutes or more duration/workout
30-45 minutes duration/workout
Less than 30 minutes
Walk
Run, jog, jump rope
Weight lift
Swim
Yoga
Others:________________

Food Frequency:

Number of servings per day:
Fruits (citrus, melons, etc.)______________________
Dark green or deep yellow vegetables __________
Grains (unprocessed)__________________________
Beans, peas, legumes ___________________________
Dairy, eggs____________________________________
Meat, poultry, fish______________________________

Current Supplements:

Multivitamin/mineral
Vitamin C
Vitamin E
EPA/DHA
Evening Primrose/GLA
Calcium, source:_______________
Magnesium
Zinc
Minerals, describe:____________
Friendly flora (acidophilus)
Digestive enzymes
Amino acids
CoQ10
Antioxidants (e.g., lutein, resveratrol, etc.)
Herbs – teas
Herbs – extracts
Chinese herbs
Ayurvedic herbs
Homeopathy
Bach flowers
Protein shakes
Super-foods (e.g., bee pollen, phytonutrient blends)
Liquid meals
Other:___________________________

Nutrition & Diet:

Mixed food diet (animal and vegetable source)
Vegetarian
Vegan
Salt restriction
Fat restriction
Starch/carbohydrate restriction
The Zone diet
Total calorie restriction

Specific Food Restriction:

dairy	wheat	eggs
soy	corn	all gluten

Eating Habits:

Skip breakfast
Two meals/day
One meal/day
Graze (small, frequent meals)
Food restriction
Eat constantly whether hungry or not
Generally eat on the run
Add salt to food

Would you like to:

Have more energy
Be stronger
Have more endurance
Increase you sex drive
Be thinner
Be more muscular
Improve your complexion
Have stronger nails
Have healthier hair
Be less moody
Be less depressed
Be less indecisive
Be more organized
Think more clearly and be more focused
Improve memory
Do better on tests in school
Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
Stop using laxatives or stool softeners
Be free of pain
Sleep better
Have agreeable breath
Have agreeable body odor
Have stronger teeth
Get less colds and flus
Get rid of allergies
Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)