MEN'S HEALTH HISTORY

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

PERSONAL

First Name: _____

Last Name: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Email: _____ How often do you check your email? _____

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

Current 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? _____

_____

_____

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? _____

MEN'S HEALTH HISTORY

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: _____

_____

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEN'S HEALTH HISTORY

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? _____

_____

_____