

**Health Coach Questionnaire**

*Please take a moment to answer the following questions thoughtfully. This simple inventory is a great start in assessing the steps necessary to improving your health. We look forward to working with you!*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**What is your main reason for scheduling this consultation?** \_\_\_\_\_

**Is there any specific information you would like covered?** \_\_\_\_\_

**I. NUTRITIONAL EVALUATION**

*Do you take nutritional supplements?* Occasionally \_\_\_ Regularly \_\_\_ Never \_\_\_

*About how many times in a 3 day period do you eat the following?*

Whole grains (not pasta or bread)		Beans		Green veggies	
Caffeine (chocolate, coffee, black tea)		Dairy		Sugar	
Processed snack foods		Red meat		Poultry	

*How often do you cook for yourself?*

Every meal \_\_\_ At least once a day \_\_\_ 2 - 3 times a week \_\_\_ Rarely \_\_\_

*Evaluate your feelings relative to:*

	Major Issue	Displeased	Fair	Good	Great
Diet					
Fitness level					
Alcohol consumption					
Weight					
Use of Medications					

**II. STRESS EVALUATION**

*Evaluate your stress relative to the following:*

	None	Slight	Moderate	Pronounced	Excessive
Family					
Partner relationship					
Health					
Finances					
Work					
School					
Sex life					
Emotional wellbeing					

### III. PHYSICAL EVALUATION

Please list any current medical conditions:

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Medications: Please list current prescription and over-the-counter medications:

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Surgical History: Please list the type of surgery and year performed:

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*Rate the incidence of the following in your life:*

	Never	Rarely	Occasionally	Frequently	Constantly
Cold/flu/infections					
Allergies/sinus issues					
Digestive issues/ heartburn/acid reflux					
Constipation/ diarrhea/hemorrhoids					
Accidents/slips/falls					
Dizziness/poor balance					
Headaches					
Physical discomfort					
Breathing difficulties					
Sleeping difficulties					
Menstrual difficulties					
Urinary issues					

### IV. EMOTIONAL EVALUATION

*Evaluate your current state relative to:*

	Major Issue	Displeased	Fair	Good	Great
Sense of ease & well-being					
Enjoyment of life					
Self-confidence					
Ability to think clearly					
Ability to handle problems					
Connection to others					
Quiet time for yourself					

*Rate the incidence of the following in your life:*

	Never	Rarely	Occasionally	Frequently	Constantly
Fatigue or low energy					
Feeling overly worried					
Feeling anxious					
Feeling depressed					
Feeling negative					
Anger/agitation					
Difficulty sleeping					
Recurring dreams					

**FOR ALL THAT MATTERS USE ONLY:**

**Pt Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Practitioner** \_\_\_\_\_

**Health Coaching Plan:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Notes:**

**Name** \_\_\_\_\_

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**Follow-up Appointment**    **Date** \_\_\_\_\_

**Client Feedback:**

**Coaching Plan Update:**

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