# Confidential Health Form

Please write or print clearly

Name: _____

Address: _____

Email address: _____

Telephone - Work: _____ Home: _____ Cell: _____

Age: _____ Date of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ Hours of work per week: _____

What are your health goals for our work together? _____

Please list your main health concerns: _____

_____

_____

At what point in your life did you feel best? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

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

_____

Constipation/Diarrhea/Gas? Please explain: _____

Do you take any supplements or medications? Please list: _____

_____

_____

What is your weekly sports and/or exercise routine? _____

_____

_____

_____

What's 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 cook? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

The most important things I should change about my diet to improve my health is: _____

_____

Anything else you want to share?