Health History Intake Form

Achievable Health 515-201-2256 achievablehealthcoach@gmail.com

Name _____ Phone Number(s) _____

Address _____

City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone Number _____

Marital Status: Single Married Partner Separated Divorced Widow(er)
Are you currently under medical supervision? Yes No
If yes, please explain _____

What medications (prescribed and over the counter) are you currently taking? _____

Have you tried any of the following therapies in the past or present to improve or relieve symptoms of your overall health?
Diet Modification Fasting Vitamins/Minerals Herbs Homeopathy Chiropractic Acupuncture
Please list all major hospitalizations, surgeries and injuries. _____

Do you consider yourself: Underweight Overweight Healthy at your weight Your weight today _____
What are your current health goals? _____

What is your expectation of hiring a health coach? _____

What is your average stress level? (10 being highest) 1 2 3 4 5 6 7 8 9 10
Have you in the past or are you currently working in a job that requires harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)? Yes No
If yes, please explain _____

Your Medical History
Please mark all that apply.

( ) Arthritis
( ) Allergies (food or environmental)
( ) Asthma
( ) Alcoholism
( ) Alzheimer's disease
( ) Autoimmune disease
( ) Blood pressure issues
( ) Bronchitis
( ) Cancer
( ) Chronic fatigue syndrome
( ) Carpal tunnel syndrome
( ) Cholesterol issues
( ) Circulatory issues (Varicose veins, Gout)
( ) Depression
( ) Diabetes
( ) Digestive (lower) system issues (Colitis, Diverticular issues, IBS)
( ) Digestive (upper) system issues (Gastroesophageal reflux disease, ulcer)
( ) Drug addiction
( ) Eating disorder
( ) Epilepsy
( ) Emphysema
( ) Ear, nose or throat issues
( ) Fibromyalgia
( ) Food intolerance
( ) Heart disease
( ) Infection, chronic
( ) Kidney or bladder disease
( ) Liver or gallbladder disease (stones)
( ) learning disability
( ) Mental illness
( ) Mental handicap
( ) Migraine headaches
( ) Neurological issues (Parkinson's, paralysis)
( ) Sinus issues
( ) Stroke
( ) Thyroid abnormalities
( ) Obesity
( ) Osteoporosis
( ) Pneumonia
( ) STD's
( ) Seasonal effective disorder
( ) Skin irregularities
( ) Tuberculosis
( ) Urinary tract infection
( ) Other _____

Men
( ) Benign prostatic hyperplasia
( ) Decreased sex drive
( ) Infertility
( ) Prostate cancer
( ) STD's
( ) Other _____

Women
( ) Menstrual Irregularities
( ) Endometriosis
( ) Infertility
( ) Fibrocystic breast tissue
( ) Fibroids/Ovarian cysts
( ) Premenstrual syndrome (PMS)
( ) Breast cancer
( ) Pelvic inflammatory disease
( ) Vaginal infections
( ) Decreased sex drive
( ) STD's
( ) Other _____
( ) Abnormal results in last PAP or mammogram
( ) Form on birth control _____
_____
# of children _____
# of pregnancies _____
( ) C- section(s) How many? _____
Age of first period _____
( ) Abnormal periods
( ) Surgical menopause
( ) Menopause Last period _____

Family Health History (Parents and Siblings)
( ) Arthritis
( ) Allergies (food or environmental)
( ) Alcoholism
( ) Alzheimer's disease
( ) Cancer
( ) Depression
( ) Diabetes
( ) Drug addiction
( ) Eating disorder
( ) Genetic irregularity
( ) Glaucoma
( ) Heart disease
( ) Infertility
( ) Learning disabilities
( ) Mental illness
( ) Mental handicap
( ) Migraine headaches
( ) Neurological issues (Parkinson's, paralysis)
( ) Obesity
( ) Osteoporosis
( ) Stroke
( ) Suicide
( ) Other _____

Health Habits

( ) Tobacco use
Cigarettes: # per day/week _____
Cigars # per day/week _____
( ) Alcohol use
Wine: # glasses per day/week _____
Beer: # glasses per day/week _____
Liquor: # ounces per day/week _____
( ) Caffeine
Coffee: # of ounces per day/week _____
Tea: # of ounces per day/week _____
Soda w/caffeine:
# of ounces per day/week _____
( ) Water: # of ounces per day _____

Exercise

( ) 1 to 2 days a week
( ) 3 to 4 days a week
( ) 5 to 7 days a week
( ) less than 30 min. workout sessions
( ) 30 to 45 min. workout sessions
( ) 45 min. or more workout sessions
Please describe your usual weekly workout regimen (ex. Yoga, aerobic exercise, weights).
_____
_____
_____

Daily Eating Habits

( ) Non-restrictive diet (mix of meat and plant-based)
( ) Vegetarian
( ) Vegan
( ) Salt restriction
( ) Fat restriction
( ) Starch/Carbohydrate restriction
( ) Calorie counting
Specific food restrictions
( ) dairy ( ) wheat ( ) eggs
( ) soy ( ) corn ( ) all gluten

Food Frequency

Number of servings on an average day:
Fruits _____
Vegetables _____
Grains _____
Beans, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Meal Tendencies

( ) Skip meals (which meal) _____
_____
( ) Eat constantly, whether you're hungry or not
( ) Eat most meals on the go
( ) Regularly eat three main meals a day
( ) Regularly eat two main meals a day
( ) Regularly eat one main meal a day
( ) Snack in between main meals of the day

Supplements and Medications

Please list all supplements that you are currently taking.
_____
_____
_____
_____
_____

I would like to:

( ) Have more energy
( ) Have more endurance
( ) Feel less tired after lunch
( ) Have a better nights rest
( ) Be pain free
( ) Have less allergy symptoms
( ) Not be as susceptible to illness
( ) Not have to use laxatives or stool softeners
( ) Not be dependent on over the counter medications
( ) Improve sex drive
( ) Lose weight
( ) Have better muscle tone
( ) Burn more body fat
( ) Be more flexible
( ) Learn ways to reduce stress
( ) Improve memory and think clearer
( ) Have less depression and moodiness
( ) Be less indecisive
( ) Have more motivation
( ) Maintain a healthier life longer
( ) Create a wellness lifestyle

Which items would you be interested in learning more about:

( ) Celiac disease
( ) High blood pressure
( ) Gluten intolerance
( ) Type I and II diabetes
( ) Raw food diet
( ) Cooking classes
( ) Menu ideas and meal time organization
( ) Book references
( ) Time management techniques
( ) Supplement Information

Notes:

I hereby acknowledge the health coaching services are provided for the primary purpose of improving the overall health habits and well-being of individuals. I understand my health coach is not a licensed medical doctor and is not qualified to diagnose, treat or prescribe medications for any physical or mental illness. I further acknowledge the services provided today are not a substitute for medical care. I acknowledge is it my sole and absolute responsibility to inform the health coach of any changes in my health and medical condition involving those categories discussed on this Health History Intake Form. By signing this form, I hereby affirm I have informed my health coach of all known medical conditions, injuries, allergies, lifestyle changes or special needs, both past and present, and I forever release, acquit, discharge indemnify and hold harmless VFR, LLC, Achievable Health, its affiliates, owners, members, officers, directors, employees, volunteers, agents, contractors, representatives, attorneys, insurers, successors, assigns (individually "Released Party"; collectively "Released Parties") from any and all actions, claims, demands, controversies or rights of whatever kind or nature that I, my assignees, heirs, distributees, guardians, next of kin, spouse, insurers and/or legal representatives now have, or may have in the future, whether now known or anticipated, or which may later develop or be discovered, including all effects and consequences thereof, related to the performance of health coaching services. I fully intend for this Release and Waiver of Liability to be binding on my assignees, heirs, distributees, guardians, next of kin, spouse, insurers and legal representatives.

If client is under 18 years of age, a parent or legal guardian must sign waiver.

Client _____ Date _____

Health Coach _____ Date _____