											Today's date:		
Client Information													
First Name:		Last Name:					Sex: ❑ M ❑ F				Marital status (circle one)		
Birth Date: / /			Age:								Single / Mar / DP / Div / Sep / Wid		
Street Address:				City, State and Zip Code:									
Home Phone: ( )		Mobile Phone: ( )									*How did you find us?*		
Email Address:													
List your top 3 health concerns:		***1)***											
		2)											
		3)											
Every day I consume: (1 serving = 1 cup) Please check number that applies to you:													
Servings of fresh fruits		❑ 5 or more		❑ 4		❑ 3		❑ 2		❑ 1	❑ 0		
Servings of vegetables, salads and green foods		❑ 5 or more		❑ 4		❑ 3		❑ 2		❑ 1	❑ 0		
Servings of water		❑ 5 or more		❑ 4		❑ 3		❑ 2		❑ 1	❑ 0		
Number of hours of sleep per night		❑ 8 + or more		❑ 7		❑ 6		❑ 5		❑ 4	❑ 3	❑ 2	❑ 1 ❑ 0
Number of bowel movements per day		❑ Diarrhea		❑ 4		❑ 3		❑ 2		❑ 1	❑ Constipated		
I usually use the following oils when I cook		❑ Coconut		❑ Butter		❑ Olive		❑ Canola			❑ Vegetable		❑ Shortening
I use the following to balance the flora in my gut		❑ Acidophilus		❑ Probiotics		❑ Kefir		❑ Yogurt			*How often?*		*/day*
I use the following sweeteners	❑ White sugar	❑ Brown sugar		❑ Splenda		❑ Honey		❑ SweetNLow			❑Stevia		❑ Xylitol
I currently have some of the following symptoms (Check all that apply)													
❑ History of ulcers or gastritis		❑ Frequent heartburn or indigestion with nausea and pain									❑ Acid reflux after eating		
❑ Frequent use of antacids		❑ Stomach pain relieved by eating				❑ Frequent belching					❑ Arm, shoulder or neck pain		
❑ Right shoulder pain/pain by scapula				❑ Frequent belching							❑ Gallbladder issues		
❑ Pain or tenderness under right rib cage				❑ Pain between shoulder blades							❑ Gas		
❑ Suffer from panic attacks						❑ Feel exhausted all the time/ tired for no reason							
❑ Consistently have low blood pressure						❑ Feel worse after exercising, not energized							
❑ Feel dizzy upon standing						❑ Have trouble getting up and out of bed in the morning							
❑ Frequent anxiety						❑ Have dark circles under my eyes							
❑ Often told that I am too serious or intense						❑ Light sleeper and/or suffer from insomnia							
❑ Often edgy or pessimistic						❑ Allergies and/or my nose runs frequently							
❑ Often feel my best before 6 p.m.						❑ Crave chocolate or salty foods (circle which)							
❑ Short term memory loss/brain fog						❑ Often suffer from headaches, migraines and muscle cramps							
❑ Low sex drive						❑ Frequently have nightmares							
❑ Trouble staying focused on my job while working						❑ Sometimes wake up between 3 and 4 a.m.							
❑ Cold hands or feet				❑ Heart palpitations							❑ Feel cold most of the time		
❑ Hard time losing weight				❑ Frequent feeling of depression							❑ Usually gain weight under my waist		
❑ Nod off easily or have sleep apnea						❑ Ringing in my ears, carpal tunnel or canker sores							
❑ Infertility problems						❑ Vertical ridges on my nails or my nails crack and/or peel							
❑ My hair is falling out or thinning						❑ History of "yo-yo" dieting							
❑ I have an energy drop in the afternoon						❑ I have a voice strain							
❑ I have dry skin						❑ Eyebrows are thinning							
❑ My pulse is < 70 or > 90						❑ Often feel my heart pounding							
❑ I have missing patches of skin pigmentation						❑ Panic of anxiety attacks in the past							
❑ I have muscle aches or cramps often						❑ Dark patches or rough skin on my elbows or heels							
❑ Family history of breast cancer						❑ My tongue is wide							
❑ Frequent headaches						❑ Frequently taken birth control pills or Aspirin in the past							
❑ My periods are irregular or very heavy						❑ I have elevated cholesterol							
❑ White spots/transverse lines on nails				❑ Dandruff				❑ Delayed wound healing					❑ Alcoholism
❑ Decrease in taste or smell sensation				❑ Pre-eclampsia (toxemia) in pregnancy							❑ Eczema and/or psoriasis		

❑ Do you have foamy bubbles in your urine when you urinate?	❑ Do you have bleeding gums?
❑ Do you have increased secretions in mouth/nose/eyes?	❑ Do you have edema (fluid) in your hands or feet?

❑ I have trigger point pain in the muscles across the upper shoulders	❑ Dry skin, dandruff, hair loss	❑ Asthma
❑ History of frequent canker sores, cold blisters, or boils	❑ Painful ribs or pain on inhalation	❑ Pain in lower back & buttocks

❑ Dry, itchy eyes or mouth	❑ Poor memory	❑ Unable to become relaxed or become serene	❑ Crave sugar	❑ Depression
❑ Frequent sore or irritated throat, sores on tongue or in the mouth			❑ History of speech impediment	

❑ Foul odor to breath and/or white film on tongue	❑ Unusually large appetite	❑ Abdominal gas	❑ Itchy skin
❑ Intense cravings for sugars, sweets and breads	❑ Frequent stomach pains and digestion problems		

How much bread do you consume daily?

MALE ONLY SECTION

❑ Prostate problems (BPH)	❑ Impotence	❑ Frequent urination	❑ Bladder irritation	❑ Low sex drive

FEMALE ONLY SECTION

❑ Do you have premenstrual breast tenderness?	❑ Polycystic ovaries	❑ Osteoporosis	❑ Foggy thinking
❑ Do you have premenstrual fluid retention and weight gain?		❑ Premenstrual headaches	
❑ Migraine headaches	❑ Acceleration of the aging process	❑ Severe menstrual cramps	
❑ Do you have heavy periods while clotting?		❑ Do you have irregular menstrual cycles?	
❑ Are you or have you taken any estrogen support		❑ Do you have uterine fibroids	
❑ Do you have endometriosis?	❑ Dry eyes ❑ Irritability	❑ Started menstruation before age 13	

❑ Decreased libido	❑ Have you had problems with infertility?	❑ History of miscarriage
❑ Anxiety or panic attacks	❑ Do you have premenstrual mood swings?	❑ Foggy thinking

❑ Inability to lose weight	❑ Acne	❑ Mood swings	❑ Headaches	❑ Racing mind	❑ Erectile Dysfunction
❑ Low blood sugar	❑ I have an inventive mind		❑ Hair loss	❑ Insomnia	❑ ADD and/or ADHD
❑ Urinary tract infections	❑ Nervousness		❑ Tendonitis	❑ Vegetarian	❑ Unexplained Nausea
❑ Excessive sexual desire	❑ I stutter	❑ Vaginal dryness	❑ Chronic yeast or infections		❑ I have a copper IUD
❑ I crave carbohydrates	❑ High blood pressure		❑ Muscle aches or pains in low back and/legs		

I have had the following health conditions:

❑ Pace maker	❑ Seizures	❑ Heart failure and/or heart attack	❑ Frequent constipation	❑ High cholesterol
❑ Bypass surgery	❑ Stroke	❑ Surgeries (date & reason)		

Tobacco Use: ❑ Never ❑ Quit _____ years ago ❑ Current user --- Type of tobacco used?

❑ **Diabetes** --- Age at onset? _____ ❑ Type 1 ❑ Type 2 ❑ I use insulin --- Amount of insulin used? _____

❑ Excessive thirst & appetite	❑ Increased urination	❑ Cuts/bruises that are slow to heal	❑ Blurred vision
❑ Tingling/numbness in the hands/feet		❑ Recurring skin, gum or bladder infections	

I drink: ❑ _____ Soda(s)/day ❑ _____ Diet soda(s)/day I drink _____ alcoholic beverages a day

Color of stools: ❑ Brown ❑ Orange ❑ Yellow ❑ White ❑ Black ❑ Green

❑ Are you taking any steroid medications?		❑ Have you had an organ transplant?	❑ Do you have gout?
❑ Are you taking birth control?	❑ Are you pregnant or nursing?	❑ Do you take any diuretics?	❑ Allergy to hCG?
❑ Do you have cancer and/or are you receiving cancer treatments?			

I take the following medications/vitamins/herbs/over the counter drugs: _____

_____

I understand that I am receiving wellness coaching to improve my nutritional health. I agree that I am receiving suggestions to improve my health. It is my choice and responsibility to improve my health. I understand these are only suggestions and I have not received any guarantees regarding these suggestions.

Printed Name: _____ Signature: _____

Coach: _____