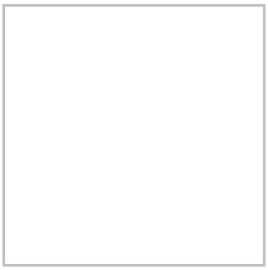

HEALTH COACH INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
Information collected about new clients is confidential and will be treated accordingly.

CLIENT INFORMATION

Name: _____ **DOB**: _____

Phone: _____ **Email**: _____

Preferred Contact Method: ☐ E-mail ☐ Phone ☐ Text Message ☐ Video Chat

Emergency Contact: _____ **Phone**: _____

GOALS

In general, what do you want out of this experience?

Please list any concerns about your health, eating habits, fitness and/or body, rating them in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please explain why the top 3 are the most important:

What do you expect from me, as your health coach?

CHANGE

Have you tried anything in the past to change your habits, health, eating and/or your body? ☐ Yes ☐ No
If yes, what?

How specifically would you like this to be different?

If you were to consider making changes to these habits, health choices and your body, what might come to mind?

Until now, what has been the biggest barrier to making these changes?

How would you rate your eating and nutrition habits on a scale of 1-10?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Why?

How many hours do you contribute to structured exercise per week?
☐ 5 or less ☐ 5-9 ☐ 10-14 ☐ 15-19 ☐ 20 or more

How many hours a week do you do other types of physical activity?
☐ 5 or less ☐ 5-9 ☐ 10-14 ☐ 15-19 ☐ 20 or more

What does your fitness program consist of currently?

ENVIRONMENT

Who lives with you? (please check all that apply)
☐ Spouse/Partner ☐ Roommate(s) ☐ Children ☐ Pets ☐ Other Family

If you have children, please list the number of children you have and their ages:

Who does most of the grocery shopping? (check all that apply)
☐ Me ☐ Spouse/Partner ☐ Roommate(s) ☐ Children ☐ Other Family

Who does most of the cooking? (check all that apply)
☐ Me ☐ Spouse/Partner ☐ Roommate(s) ☐ Children ☐ Other Family

Who decides the menu for the week? (check all that apply)
☐ Me ☐ Spouse/Partner ☐ Roommate(s) ☐ Children ☐ Other Family

How supported would you say you feel by the people and things around you on a scale of 1-10? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

TIME

How many hours per week would you say you spend on the following:

_____ Paid Employment
_____ At School
_____ Unpaid Work (housework, errands)
_____ Taking Care of Others
_____ Travel/Commuting
_____ Volunteering

On a scale of 1-10, how do you feel about your schedule, use of time, and overall busyness? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

STRESS & RECOVERY

What is your typical stress level on an average day?
☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ High Stress ☐ Very High Stress

On average, how many hours of sleep do you get per night?
☐ 4 or less ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

How do you normally cope with your stress?

How READY are you to change your behaviors and habits?
☐ Not at All ☐ Somewhat Ready ☐ Extremely Ready ☐ 100% Ready

How WILLING are you to change your behaviors and habits?

☐ Not at All ☐ Somewhat Willing ☐ Extremely Willing ☐ 100% Willing

How ABLE are you to change your behaviors and habits?

☐ Not at All ☐ Somewhat Able ☐ Extremely Able ☐ 100% Able

HEALTH MARKERS

How would you currently rank your health on a scale of 1-10?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

- Why?

Please list any injuries, surgeries or illnesses that you have had in the past.

Please list any medications and/or supplements that you are currently taking.

DISCLAIMER

Please recognize that it is your responsibility to work directly with your health care provider before, during, and after seeking nutrition or fitness consultation. Any information provided is not to be followed without prior approval of your doctor. If you choose to use this information without such approval, you agree to accept full responsibility for your decision.

CLIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____