HEALTHY LIFESTYLE MANAGEMENT PROGRAM

January 2, 2017 - March 31, 2017

Personal Information:

Name:

Address:

Phone: (mobile or landline)

Email:

Social Media: Facebook: Instagram: Twitter:

Age: Current Weight: Weight 6 months ago: Weight 1 yr ago:

Social Information:

Relationship status:

Current living situation: #adults in your home: #Children: #pets:

Occupation: Hours of work per week: % of job satisfaction:

What do you do for fun?

What makes your heart happy?

What are your hobbies?

What would you like to change about your social situation? (yes, list everything!)

Basic Health Information

Last Dr. Visit? For what purpose?

Allergies: Food sensitivities:

Please list your health concerns:

Serious illnesses, hospitalizations or injuries:

Any pain, stiffness or swelling? Pain in your joints?

Do you experience constipation/diarrhea/gas/bloating?

Other concerns and/or goals (anything you think I should know):

Medications:

Supplements:

What is your best weight? What is your goal weight for this program?

How is your sleep? How many hours? Do you wake up at night? Why?

What is your level of activity? Do you exercise regularly? How often?

What types of activities?

How is/was the health of your mother?

How is/was the health of your father?

What is your blood type?

Any healers, helpers, or therapies with which you are involved? Please list:

Do you want more information about a detox option? If Yes, circle: 3 7 14 21 days

Food Information

What foods did you eat often as a child?

What foods do you eat often these days?

Will family and/or friends be supportive as you make food and/or lifestyle changes?

Do you cook? What % of your food is home-cooked?

How often do you eat out? What type of food do you seek while out?

Do you crave sugar, coffee, cigarettes, caffeine, or other foods?

Do you have any major addictions?

Do you currently use a protein meal replacement or make smoothies?

The most important thing I should do to improve my health is: