



## Men's Health History Form

All of your information will remain confidential between you and the Health Coach.

### Personal Information

First Name\* \_\_\_\_\_ Last Name\* \_\_\_\_\_

Address \_\_\_\_\_ Suite/Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email\* \_\_\_\_\_ How often do you check e-mail? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Place of Birth \_\_\_\_\_

Current weight \_\_\_\_\_ Weight six months ago \_\_\_\_\_ One year ago \_\_\_\_\_

Would you like your weight to be different?    Yes    No    If yes, please explain:

Relationship status \_\_\_\_\_

Children \_\_\_\_\_ Pets \_\_\_\_\_

Occupation \_\_\_\_\_ Hours of work per week \_\_\_\_\_

### Health Information

Please list your main health concerns:

Other concerns and/or goals?

At what point in your life did you feel best?

Any serious illnesses/hospitalizations/injuries?      Yes      No      If yes, please explain:

How is/was the health of your mother?

How is/was the health of your father?

What is your ancestry? \_\_\_\_\_ What blood type are you? \_\_\_\_\_

Do you sleep well?      Yes      No      How many hours? \_\_\_\_\_

Do you wake up at night?      Yes      No      If yes, please explain:

Any pain, stiffness or swelling?      Yes      No      If yes, please explain:

Constipation/Diarrhea/Gas?      Yes      No      If yes, please explain:

Allergies or sensitivities?      Yes      No      If yes, please explain:

## Medical Information

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Do you take any supplements or medications? If so, please list:

Any healers, helpers or therapies with which you are involved? If so please elaborate:

What role does sports and exercise play in your life? Please explain:

## Food Information

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What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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?

Yes

No

Do you cook?

Yes

No

What percentage of your food is home-cooked? \_\_\_\_\_ %

Where do you get the rest of your food from?

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

Yes

No

If yes, please explain:

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

### **Additional Comments:**

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Anything else you would like to share?: