MEN'S HEALTH HISTORY

NJ RECOVERY & WELLNESS

Your information will remain confidential between you and your Health Coach.

PERSONAL

First Name: ____

Last Name: ____

Age: ________ Height: ____________ Date of Birth: ____________ Place of Birth: ____________________

Email: ______________________________

Mobile Phone: ________________________

Current Weight: ____________ Weight Six Months Ago: ___________ Weight One Year Ago: ______________

Would you like your weight to be different? __________ If so, how?________________________________

SOCIAL

Relationship Status: ____

Where do you live? ____

Any children? ____________________________________ Any pets? ____________________________

Occupation: _____________________________________ How many hours do you work per week? __________

GENERAL HEALTH

What are your main health concerns? ____

____

____

Any other concerns and/or goals? ____

____

____

At what point in your life did you feel your best? ___________________________________

Any current or previous serious illnesses, hospitalizations, or injuries? _______________________

____

How is/was your mother's health? ____

How is/was your father's health? ____

What is your ancestry? ____

MEN'S HEALTH HISTORY

GENERAL HEALTH (continued)

How is your sleep? ________________________ How many hours do you sleep per night? ________

Do you wake up during the night? If so, why? ____

Any pain, stiffness, or swelling? ____

Any constipation, diarrhea, or gas? ____

Any allergies or sensitivities? ____

MEDICAL

List all supplements or medications: ____

____

Are you involved with any healers, helpers, or therapies? ____

____

What role do sports and exercise play in your life? ____

____

FOOD

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? ____________

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

Where does your non-home-cooked food come from? ____

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

FOOD (continued)

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

____

What do you think is the most important thing you should change about your diet to improve your health? ________

____

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ADDITIONAL COMMENTS

Is there anything else you would like to share? ____

____

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