SUPPORTING BALANCE - holistic Coaching

			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 Post 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 oedema (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 odour 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:					
☐ Pacemaker	☐ 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?			☐ Allergy to hCG?		
☐ Are you taking birth control?	☐ Are you pregnant or nursing?		☐ Do you take any diuretics?		
☐ Do you have cancer and/or are you receiving cancer treatments?					
Any past medical diagnosis? ☐ Yes ☐ No					
Have you taken the following in the past? ☐ Vitamin D ☐ Calcium ☐ Multi-vitamins ☐ Vitamin C ☐ Iron ☐ Zinc ☐ B12 ☐ Herbal remedies ☐ Meal replacement shakes ☐ Liver cleanses ☐ Others					
How do you rate your childhood in terms of happiness, confidence, stress, sickness - 😭 😐 😊 Please also rate how you felt about your childhood from 1 to 10 _____ (1 = unhappy, not positive memories - 10 = content and +ve) Any particular reasons for these ratings?					
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:					