***Whole Body Works: When your food, sleep, movement, work, relationships, joy/fun factors & spirit feels balanced.***

**HEALTH HISTORY FORM**

Please type—or print clearly. This form is confidential. The more you feel comfortable and fill out the more detail we’ll have to work with and the clearer you will be on your goals

Name:

Street Address:

E-Mail Address:

Landline Phone: Mobile Phone:

Birth Date: Age: Place of Birth:

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

Would you like your weight to be different: If so, what:

Relationship Status: Do you have children/Number/Names

Do you have pets/type/name(s)

Occupation/Career: Hours of Work Per Week:

Do you enjoy your job?

Passions/Hobbies/Fun:

Hours toward this play per week:

What role does movement/exercise play in your life:

If so, what type of movement do you do?

Number of times you have movement during an average week?

Do you sleep well? Do you wake up at night?

If so, what times do you wake up/why?

What time do you generally get up/go to sleep?

Constipation/Diarrhea: Explain:

What blood type are you? What is your ancestry?

Women: Do you get your period? How many days in your flow?

Painful or Symptomatic: Please explain:

If you are post-menopausal, when was your last period?

If applicable, how is the health of your mother:

If applicable, how is the health of your father:

Do you currently take any supplements or medications:

If so, which:

Have you had any specific illness /hospitalization/injury in the past five years?

If so, when & please explain:

Do you drink coffee? If so, how many cups per day:

Do you smoke cigarettes or have any major addictions?

If so, please explains:

What is your major source of stress?

How well would you say you manage your stress?

How is your energy level?

How is your general mood?

Do you have any spiritual practice (I.E. prayer group, church-goer, meditation, etc)?

What is your chief concern?

What are your other concerns?

What percentage of your food is home cooked?

Where do you get the rest from:

How much time do you allow yourself to eat:

Breakfast

Lunch:

Dinnner:

**Please be as detailed as possible:**

**What foods did you eat as a child?**

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What about a year ago:

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What’s your food intake like today? (Be as detailed as possible to showcase as much as you can here, please)

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What else do you wish/need/want to share here that wasn’t covered in the aforementioned information/detail/questions?

**Mela Stevens Consulting Mela Stevens Nutrition & Wellness Coaching**

**Mela Stevens, CHHC, RYT-500 Coaching for an extraordinary life for the past baker’s dozen years!**

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**Myers Briggs Certified Facilitator**

**In—process training as a Quantum Coach re certification for the International Coaching Federation and National Health & Wellness Coaching**

**Nutrition-Wellness-Performance-Development-Business= Life**

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