Lifestyle Assessment Form

First Name: **Last Name:**

Address:

City: **State:** **Zip Code:**

Home Phone: **Mobile Phone:**

Email Address:

Marital Status: **Children:**

Pets:

Occupation: **Hours Worked Per Week:**

Age: **Date of Birth:** **Blood Type:** **Height:**

Current Weight: **Weight 6 Mo. Ago:** **Weight 1 Year Ago:**

Desired Weight:

What are Your Goals:

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

List Your Main Health Concerns:

1.

2.

3.

When Did You First Experience These Concerns:

How Have You Dealt with These Concerns in the Past (Doctors or Self-Care):

How Has This Worked Out:

What Other health professionals are you seeing now?

How often have you taken antibiotics:

- During infancy/childhood:
- During adolescence:
- During adulthood:

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

Have other family members had similar problems, please describe:

Do you suffer from or are you concerned about any of the following:

Headaches	Chronic pain	Gas/bloating
Trouble Sleeping	ADD/ADHD	Hives
Anxiety	Stress	Heart Disease
Mood Swings	Heartburn	Cancer
Depression	Reflux	Diabetes
High Cholesterol	Constipation	High Blood Pressure
Low energy	Diarrhea	Other:

List Typical Foods You Eat Now:

Breakfast	Lunch	Dinner	Snacks	Liquids

Have you tried to lose weight before:

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

If so, what have you tried:

Are there any foods that you avoid because of the way they make you feel:

Do you experience any symptoms shortly after eating:

What is your biggest challenge with eating healthfully:

Are there food that you crave, please explain:

Do you have any known food allergies or sensitivities:

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

Which of the following do you consume regularly:

- ☐ Soda/Pop
- ☐ Diet Soda
- ☐ Sugar
- ☐ Artificial Sweetener
- ☐ Alcohol
- Fast Food
- Gluten (Wheat, Rye, Barley)
- Dairy (Milk, Cheese, Yogurt)
- Coffee

Are you following a special diet or lifestyle plan:

What percentage of your meals are home-cooked:

Is there anything else you would like to share about your current diet/history:

Please take a moment to describe your intestinal status/bowel movements:

Frequency:

Consistency:

Color:

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

Do you experience intestinal gas, pleas describe (frequency, odor):

Have you been exposed to any Chemicals or toxic metals:

Do odors affect you:

Are you affected by secondhand smoke:

Do you have mercury amalgam fillings:

How do you handle stress:

How do you sleep:

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

© Zenful Life Coaching LLC | www.zenfullifecoaching.com

How do you see a Nutrition Counselor/Health Coach helping you:

☐ Emotional Eating	Better digestion	Affordable health foods
☐ Craving control	Lower cholesterol	Body image
☐ Portion Control	Disease avoidance	Picky Eaters
☐ Motivation	Addictions	Immunity
☐ Inspiration	Thyroid Issues	Holiday Strategies
☐ Education	Metabolism	Traveling Strategies
☐ Weight Loss	Digestive issues	Dining Out Strategies
☐ Meal Plans	Detox and cleanses	Fueling for fitness
☐ More Energy	Learning what to eat	Clean Protein
☐ How to Cook	Healthful food sources	Kitchen food overhaul
☐ Food Intolerances	Learning What foods to avoid	Better Sleep
☐ Pain Relief	Helping a family member	Adrenal fatigue
☐ Lifestyle Makeover	Stress management	Recipes
☐ Mood Stability	Diarrhea	Other:

Do you exercise, how much:

Have you lived or traveled outside if the US, if so, when and where:

Have you or a family member recently experienced any major life changes, if so, what:

How are your moods in general:

How often are you affected by:

- **Depression:**
- **Anxiety:**
- **Anger:**
- **Poor self-image/worth:**

On a scale from 1-10 describe your normal energy level:

For Women

How are/were your menses:

Do/did you have PMS:

Painful periods, please explain:

Any breast tenderness, water retention, irritability, or other symptoms:

Have you experiences any yeast infections or urinary infections, if so, are they regular:

Have you/do you take birth control pills, if so, please list length of time and type:

Have you had any problems with conception or pregnancy:

Are you taking any hormone replacement therapy or hormonal herbs, if so, please list:

Are you interested in a holistic approach to health coaching, including talking about and getting resources for improvement in other areas of your life like relationships, career, personal growth, and spirituality:

At what point in your life did you feel your best, why:

Do you have friends/family that will support you in any lifestyle changes you choose to make:

Tell me a couple goals/aspirations you hope to get out of these sessions:

Any other information you would like to share that will aid in your progress:

To submit this form: 1. Save form to your desktop; 2. Click submit; 3. Attach the form from your desktop to the email that pops up.

Submit

© Zenful Life Coaching LLC | www.zenfullifecoaching.com