# CLIENT Intake FORM

3 MONTH HEALTH COACHING PROGRAM

Kimmie Whitman

# CLIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health

## PERSONAL INFORMATION

NAME

AGE

HEIGHT AND WEIGHT

GOAL WEIGHT

## CONTACT INFORMATION

EMAIL ADDRESS

PHONE NUMBER

HOME ADDRESS

CITY, STATE

ZIP CODE

HOW MAY I CONTACT YOU? PHONE ◯ EMAIL ◯

## PERSONAL HEALTH HISTORY

| MEDICAL DIAGNOSIS | |
|---|---|
| | |
| | |
| | |
| | |
| | |

| MEDICATIONS AND SUPPLEMENTS | |
|---|---|
| | |
| | |
| | |
| | |

## LIST YOUR CURRENT HEALTH/WELLNESS CONCERNS

## DIET AND LIFESTYLE

How much water do you drink daily?

What is your current diet like?

- [ ] Standard Diet
- [ ] Vegetarian/Vegan
- [ ] Low-Carb Diet
- [ ] Paleo
- [ ] Other If "Other", please specify

Describe your relationship with food

Do you experience digestive difficulties?

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep?

How often do you exercise?

What types of exercise do you do?

What level of stress are you currently experiencing?

Is there anything that will get in the way of following a treatment plan in order to achieve results?

## MEASUREMENTS

TAKE MEASUREMENTS ON TOP OF UNDERGARMENTS

- [ ] CHEST
- [ ] NATURAL WAIST
- [ ] RIGHT THIGH
- [ ] LEFT THIGH
- [ ] RIGHT BICEP
- [ ] LEFT BICEP
- [ ] HIPS
- [ ] NECK

## PERSONAL GOALS

LIST YOUR GOALS AND WHAT YOU HOPE TO GET OUT OF THIS 3 MONTH PROGRAM.

1.
2.
3.
4.
5.