	Today’s date:

Client Information

First Name:	Last Name:	❑ M ❑ F	Marital status (circle one)
Birth Date: / /	Age:	Blood Type:	Single / Mar / DP / Div / Sep / Wid
Street Address:	City, State and Zip 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 edema (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 odor 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
- ❑ Erectile Dysfunction

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
- ❑ History of miscarriage

- ❑ Decreased libido
- ❑ Have you had problems with infertility?
- ❑ Anxiety or panic attacks
- ❑ Do you have premenstrual mood swings?
- ❑ Foggy thinking

- ❑ Inability to lose weight
- ❑ Acne
- ❑ Mood swings
- ❑ Headaches
- ❑ Racing mind
- ❑ 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:

- ❑ Seizures
- ❑ Stroke
- ❑ Frequent constipation
- ❑ High cholesterol
- ❑ Bypass surgery - Date of Surgery:
- ❑ Heart failure and/or heart attack - Date of Heart Attack:
- ❑ Pace maker - Date Installed:
- ❑ 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?
❑ Are you taking birth control?	❑ Are you pregnant or nursing?	❑ Do you take any diuretics?	
❑ Allergy to hCG (Pregnancy Hormone)?			
❑ Do you have cancer and/or are you receiving cancer treatments?			

I take the following medications/vitamins/herbs/over the counter drugs: ____________________

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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: Mary Theresa Jurnack