



Health Coaching

Name: _____ Date: _____

GENERAL HEALTH

What are your main health concerns? _____

How are you feeling (poor energy, lack of sleep, etc.)? _____

Any other concerns and/or goals? _____

At what point in your life did you feel your best? _____

FOOD

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Where does your non-home-cooked food come from? _____

What foods do you typically eat these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you crave sugar, coffee, or cigarettes? _____ Do you have any other major addictions? _____

What is the most important thing you should change about your diet to improve your health? _____

MY RECOMMENDATIONS