WRIGHT WELLNESS
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1398 W. Mayfield Rd, Suite 220
Arlington, TX 76015
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682.777.4325

Health Coaching Questionnaire

"Getting to know you better: Sharing your journey"

Client Information

Name: _____Age_____Date of Birth:____/____/____

Phone Number: _____Email Address: _____

Home Address: _____

Gender: _____Occupation:_____

Emergency Contact: *If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? By listing someone below, you give permission for them to be contacted in the case of an emergency:*

Name: _____Phone Number: _____

Relationship: _____

Please tell me why you are seeking my professional help: _____

_____

_____

_____

What are your specific health goals? _____

_____

_____

_____

Why are you wanting to make health/nutrition/lifestyle changes now? _____

_____

_____

_____

What healthy habits have you tried in the past that have worked for you? _____

_____

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What have you done in the past that hasn't worked for you? _____

Please share with me any past health conditions or procedures you have had:

Please share with me any health conditions you are currently experiencing:

Do you suffer from autoimmune conditions? ❑ No ❑ Yes If so, please describe:

Tell me about your energy levels: _____

Tell me about your exercise frequency/duration and regimen, if any: _____

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Tell me about your hunger levels throughout the day: _____

_____

_____

What are some of your typical meals and snacks? _____

_____

_____

What percent of the time do you cook your own meals? Where do you get the rest of your food? _____

_____

_____

How much water and non-caffeinated drinks (if not water, specify) do you drink per day, on average? _____

_____

How much caffeine do you drink on a typical day? _____

_____

Do you consume alcohol? ❑ No ❑ Yes If so, how many drinks per week? _____

_____

_____

Do you smoke? ❑ No ❑ Yes If yes, how many cigarettes a day? _____

_____

Do you have any known food intolerances? ❑ No ❑ Yes If so, please describe:

_____

_____

Do you have any known seasonal/other allergies? ❑ No ❑ Yes If so, please describe:

_____

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Do you have any cravings? ❑ No ❑ Yes If you have cravings, are they ongoing or during certain times of month or when specific emotions arise?

How do you respond to cravings? _____

How would you describe your relationship with food? _____

Do you have any digestive issues/problems? ❑ No ❑ Yes If so, please describe:

How many hours do you sleep, on average? How would you describe the quality of your sleep? _____

Please list any past or existing health conditions of people in your immediate family:

Please describe to me your current living/family situation: _____

Do you have a strong support network? ❑ No ❑ Yes Please describe: _____

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How are you hoping that I can be of help to you? _____

Are you currently seeking help from other health practitioners? ❑ No ❑ Yes

If yes, please list their names (if you are comfortable) and what you are being seen for:

Are you currently taking any medications, vitamins, or supplements (prescribed or OTC) and are you experiencing any side effects from these? ❑ No ❑ Yes If so, please list:_____

On a scale of 1-10 (1 being not at all, 10 being completely!), how committed are you to making long-term modifications to improve your health and lifestyle?

Please feel free to share any other relevant information or anything you feel would benefit our work together:

I really look forward to getting to know you better and to accompanying you on your health journey! -Dana Shafir, Ph.D., LPC, Health Coach