Sharon McRae

Certified Health Coach

Men's Health History

Personal Information

Name: *

Address:

Email: *

How often do you check e-mail:

Home Phone:

Work Phone:

Cell Phone:

Age:

Height:

Birthdate:

Place of Birth:

Current Weight:

Weight six months ago:

One year ago:

Would you like your weight to be different:

If so, what?:

Social Information

Relationship status:

Children:

Pets?:

Occupation:

Hours of work per week:

Health Information

Please list your main health concerns:

Other concerns and/or goals?:

At what point in your life did you feel best:

Any serious illness/hospitalizations/injuries:

How is/was the health of your mother?:

How is/was the health of your father?:

What is your ancestry?:

What blood type are you?:

Do you sleep well?:

How many hours?:

Do you wake up at night?:

Why?:

Any pain, stiffness or swelling?:

Constipation/Diarrhea/Gas?:

Allergies or sensitivities? Please explain:

Medical Information

Do you take any supplements or medications?:

Please List:

Any healers, helpers, pets or therapies with which you are involved?:

Please List:

What role do sports and exercise play in your life?:

Food Information

What foods did you eat often as a child?

Breakfast:

Lunch:

Dinner:

Snacks:

Liquid:

What's your food like these days?

Breakfast:

Lunch:

Dinner:

Snacks:

Liquid:

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

Do you cook?:

What percentage of your food is home cooked?:

What percentage is not?:

Where do you get the rest from?:

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

The most important thing I should change about my diet to improve my health is:

Additional Comments

Anything else you would like to share?:

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