**First Name:****Last Name:****Sex:** **[ ] Male** **[ ] Female**

**My top 3 concerns today about my health(1)****(2)****(3)**

**How did you hear about the 21 Plan?**

**Date of Birth**:       **Age**:      **Phone Number: (****)**

**Street:****City:****State:****Zip:**

**Temperature Log (See Attached)Day 1:****Day 2:****Day 3:****Day 4:****Day 5:****Day 6:**

**Number of pounds overweight as seen by yourself?**

***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, salad, and green foods…** **[ ] 5 or more** **[ ]  4** **[ ] 3** **[ ] 2** **[ ] 1** **[ ] 0**

**Servings of water (8 oz. cups).……………………** **[ ] 5 or more** **[ ] 4** **[ ]  3** **[ ] 2** **[ ] 1** **[ ] 0**

**Servings of fried foods per day……………………** **[ ] 5 or more** **[ ] 4** **[ ] 3** **[ ] 2** **[ ] 1** **[ ] 0**

**Number of bowel movements per day……………** **[ ] Diarrhea** **[ ] 4** **[x] 3** **[ ] 2** **[ ] 1** **[ ] 0** **[ ] Constipated**

**Number of hours of sleep per night………………** **[ ] 8+ or more** **[ ]  7** **[ ] 6** **[ ] 5** **[ ] 4** **[ ]  3** **[ ] 2** **[ ] 1** **[ ] 0**

**I usually use the following oils when I cook:** **[ ] Butter** **[ ] Coconut** **[ ] Olive** **[x] Canola** **[ ] Vegetable** **[ ] Shortening**

**I use the following to balance the flora in my gut:** **[ ] Acidophilus****[ ] Probiotics****[ ] Kefir****[ ] Yogurt How often?**

**I use the following sweeteners:**

**[ ] White Sugar** **[ ] Brown Sugar** **[ ] Splenda** **[ ] Sweet-N-Lo** **[ ] Honey** **[ ] Stevia** **[ ] Xylitol How often?**

**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

[ ] I suffer from panic attacks [ ] Feel exhausted all the time/ tired for no reason

[ ] I consistently have low blood pressure [ ] Feel worse after exercising, not energized

[ ] Feel dizzy upon standing [ ] I have trouble getting up and out of bed in the morning

[ ] Frequent anxiety [ ] I have dark circles under my eyes

[ ] I am often told that I am too serious or intense [ ] I have yellow or thick big toe nails

[ ] I am often edgy or pessimistic [ ] Allergies and/or My nose runs frequently

[ ] I often feel my best after 6 p.m. [ ] I crave chocolate or salty foods (circle which)

[ ] Short term memory loss/ brain fog [ ] I often suffer from headaches, migraines, and muscles cramps

[ ] Low sex drive [ ] I frequently have nightmares

[ ] Trouble staying focused on my job while working [ ] I sometimes wake up between 3 and 4am

 [ ] Light sleeper and/or suffer from insomnia

[ ] Cold hands or feet [ ] I have heart palpitations [ ] I tend to be cold most of the time

[ ] I have a hard time losing weight [ ] When I gain weight it is usually around my waist

[ ] I nod off easily or have sleep apnea [ ] I have ringing in my ears, carpal tunnel, or canker sores

[ ]  Infertility problems [ ] I have vertical ridges on my nails or my nails crack and/or peel

[ ]  My hair is falling out or thinning [ ] I have a history of “yo-yo” dieting

[ ] I have an energy drop in the afternoon [ ] I have plantar fasciitis/pain on soles of feet

[ ] I have dry skin [ ] My eyebrows are thinning

[ ] My pulse is <70 or > 90 [ ] I often feel my heart pounding

[ ] I have missing patches of skin pigmentation [ ] I have had panic or anxiety attacks in the past

[ ] I have muscle aches or cramps often [ ] I have dark patches or rough skin on my elbows

[ ] Family history of breast cancer [ ] My tongue is wide

[ ] Frequent headaches [ ] I have frequently taken birth control pills or Aspirin in the past

[ ] My periods are irregular or very heavy [ ] I have had problems with depression

[ ] I have elevated cholesterol [ ] I have a voice strain

[ ] White spots on fingernails and/or transverse lines [ ] Dandruff [ ] Delayed wound healing [ ] Alcoholism

[ ] Decrease in taste or smell sensation [ ] Pre-eclampsia (toxaemia) in pregnancy [ ] Eczema and/or psoriasis

[ ] Prostate problems (VPH) [ ] Impotence [ ] Frequent Urination [ ] Bladder irritation [ ] Low sex drive

[ ] 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

[ ] Right shoulder pain or pain by scapula [ ] Do you have a belching problem [ ] Gallbladder issues

[ ] Pain or tenderness under the rib cage on the right side [ ] Pain between shoulder blades [ ] Gas

**[ ] Diabetes: (Age at onset ) [ ] Type 1or [ ] Type 2 [ ] I use insulin (amount of insulin used     )**

[ ] Excessive thirst and appetite [ ] Increased urination [ ] Blurred vision [ ] Cuts/bruises that are slow to heal

[ ] Tingling/numbness in the hands/feet [ ] Recurring skin, gum, or bladder infections

[ ]  Do you see foamy bubbles in your urine when you urinate? [ ] Do you have bleeding gums?

[ ] Do you have an increased secretions in mouth/nose/eyes?[ ] Do you have edema (fluid) in your hands or feet?

**I have had the following health conditions:** [ ] Pacemaker [ ] Seizures [ ] Heart failure and/or heart attack[ ] Frequent Constipation [ ] High cholesterol [ ] Bypass surgery [ ] Stroke [ ] Chronic pain     (where)

[ ] High blood pressure [ ] Cancer [ ] Surgeries (date)

Tobacco Use: [ ] Never [ ] Quit       years ago [ ] Current user Type of tobacco used

**Female Section Only: When was your last menstrual cycle?**

[ ] Do you have premenstrual breast tenderness [ ] Do you have premenstrual mood swings

[ ] Do you have premenstrual fluid retention and weight gain [ ] Premenstrual headaches

[ ] Migraine headaches [ ] Severe menstrual cramps

[ ] Do you have heavy periods with 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 [ ] Have you had problems with infertility

[ ] Have you had a miscarriage [ ] Started menstruation before age 13

[ ] Do you have a decreased libido [ ] Do you have anxiety or panic attacks

**Ideally, how often would you like to be contacted by your weight loss coach?**

[ ] Daily [ ] Every couple of days [ ] Every three-five days [ ] I will contact the coach when I have questions

**Would you like your coach to text message you?** If yes, what number do you receive text messages?(     )

**Would you like your coach to e-mail you?** If yes, what e-mail address do you prefer?

**How much soda and diet soda do you drink in a day** (***put amounts for both***)?

**How many alcoholic beverages do you consume daily**?

**How much white bread and sugar do you consume daily**?

**Typically, what color are your bowel movements**?

**In the next six weeks, do you have any special occasions coming up (vacations, birthdays, anniversaries, etc…) If yes, what type of occasion and when?**

**Are you comfortable with cooking and** **preparing your own meals**? [ ] Yes [ ] No [ ] Sometimes

[ ] 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?

[ ] Do you have cancer and/or are you receiving cancer treatments?

Medicine/vitamins/herbs: I take the following medications

I regularly take these **over-the-counter *drugs, herbs, vitamins:***

***I understand that I am receiving wellness coaching for weight loss. 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.***

 **Signature Date Coach**