**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** **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** **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 attackFrequent 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**