Fuel YOUR Best Life
Senior Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Best number to reach you: _____

Age: _____ Height: _____ Date of Birth: _____ 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: _____

Where do you currently live? _____

Grandchildren: _____

Occupation: _____ Hours of work per week: _____

What is your retirement plan? _____

HEALTH INFORMATION

List your main health concerns: _____

_____

_____

Other concerns or goals?

_____

_____

HEALTH INFORMATION (continued)

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

Any serious illnesses/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? _____

How is your sleep? _____ 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, or therapies with which you are involved? Please list: _____

_____

What role does exercise play in your life?

_____

What is your energy like? _____

Do you still feel independent? Please explain: _____

_____

Anything else you would like to share?_____