



Men's Confidential Health Intake Form



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Please write or print clearly

NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____ WORK PHONE: _____

HOME PHONE: _____ CELL PHONE: _____

AGE: _____ HEIGHT: _____ DATE OF BIRTH: _____

PLACE OF BIRTH: _____ CURRENT WEIGHT: _____

WOULD YOU LIKE YOUR WEIGHT TO BE DIFFERENT? _____ IF SO, WHAT? _____

RELATIONSHIP STATUS: _____

CHILDREN: _____ PETS: _____

OCCUPATION: _____ HOURS OF WORK PER WEEK: _____

PLEASE LIST YOUR MAIN HEALTH CONCERNS: _____

OTHER CONCERNS AND/OR GOALS? _____

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? _____

DO YOU SLEEP WELL? _____ HOW MANY HOURS? _____

ANY PAIN, STIFFNESS OR SWELLING? _____

CONSTIPATION/ DIARRHEA/ GAS? PLEASE EXPLAIN: _____

ALLERGIES OR SENSITIVITIES? PLEASE EXPLAIN: _____

DO YOU TAKE ANY SUPPLEMENTS OR MEDICATION? PLEASE LIST: _____

ANY HEALERS, HELPERS OR THERAPIES WITH WHICH YOU ARE INVOLVED? PLEASE LIST: _____

WHAT ROLE DOES SPORTS AND EXERCISE PLAY IN YOUR LIFE? _____

WHAT ARE YOUR HOBBIES? _____



WHAT DOES YOUR DIET LOOK LIKE THESE DAYS?

BREAKFAST _____

LUNCH _____

DINNER _____

SNACKS _____

LIQUIDS _____

ARE YOU A SLOW, MODERATE OR FAST EATER? PLEASE EXPLAIN: _____

WILL FAMILY AND/OR FRIENDS BE SUPPORTIVE OF YOUR DESIRE TO MAKE FOOD AND/ OR LIFESTYLE CHANGES? _____

WHAT PERCENTAGE OF YOUR FOOD IS HOME COOKED? _____ DO YOU COOK? _____

WHERE DO YOU GET THE REST FROM? _____

DO YOU CRAVE SUGAR, COFFEE, CIGARETTES, OR HAVE MAJOR ADDICTIONS? _____

THE MOST IMPORTANT THING I SHOULD CHANGE ABOUT MY DIET TO IMPROVE MY HEALTH IS:

ANYTHING ELSE YOU WANT TO SHARE? _____
