Health Intake Form

Leanne Harris Health Coaching & Wellness Education

1. Why are you seeking help now?

_____

2. What goals would you like to set for your health? (Looking for a "quick fix" or a lifestyle change?)

_____

3. What all have you tried that has not worked for you?

_____

4. Are you under unusual stress?

_____

5. What diagnoses have you been given?

_____

6. Do you have allergies to food or medicine?

_____

7. Do you take supplements and medications? Y N

If yes, for what? _____

8. Rate your current health habits with 10 being the absolute best and 0 being totally nonexistent.

- Your water intake (one half of your body weight in ounces everyday)
- Your sleep quality and time (no waking, solid 8 hours)
- Your exercise and movement (30 mins daily)
- Your gratitude practice (reading, using affirmations, meditation and prayer, positive community)
- Your fruit and vegetable intake (A variety of at least 7 servings the size of your fist a day.)
- Your food quality (mostly organic, mostly raw) Explain:

_____

PLEASE USE DROP-DOWN FEATURE TO THE LEFT OF EACH BULLET POINT TO RATE EACH SELECTION ABOVE

HEALTH INTAKE FORM

LEANNE HARRIS • WHOLE FOOD WORKS

9. What time do you eat your meals? ____ Do you snack in between? Y N

10. Do you eat food products with dairy? Y N

If yes, please list: _____

11. Do you eat food products with wheat/gluten? Y N

If yes, please list: _____

12. Do you have a problem with sugar cravings? Y N

If yes, please list: _____

13. Do you consume products with food dyes? Y N

If yes, please list: _____

14. Do you take vitamin supplements? Y N

If yes, please list: _____

15. Do you like to shop for food? Y N

16. Do you like to prepare meals? Y N

17. Are you interested in learning to shop differently and make dishes that will support your health goals? Y N