*Hygge*Body • Men's Health History Form

Please write or print clearly. Your information will remain ***confidential*** between you and your Health Coach. Should you feel uncomfortable answering any questions, you may leave them blank.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Age: _____ Height: _____ Date of Birth: _____

Place of Birth: _____

Email: _____

How often do you check your email? _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Current Weight: _____ Weight Six Months Ago: _____

Weight One Year Ago: _____

Would you like your weight to be different? _____ If so, how?_____

_____

SOCIAL

Relationship Status: _____

Where do you live? _____

Any children? _____Any pets? _____

Occupation: _____

How many hours do you work per week? _____

GENERAL HEALTH

What are your main health concerns? _____

Any other concerns and/or goals? _____

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

Any current or previous serious illnesses, hospitalizations, or injuries? _____

How is/was your mother's health? _____

How is/was your father's health? _____

Were you born by cesarean section? _____

Were you breast fed? _____

What is your history of antibiotic use?_____

What is your ancestry? _____

What is your blood type? _____

How is your sleep? _____

How many hours do you sleep per night? _____

Do you wake up during the night? If so, why? _____

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

MEDICAL

List all supplements or medications: _____

Are you involved with any healers, helpers, or therapies? _____

What role do sports and exercise play in your life? _____

FOOD

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____

What percentage of your food is home-cooked? _____

Where does your non-home-cooked food come from? _____

_____

_____

_____

_____

What foods did you eat often as a child?

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Snacks:_____

_____

_____

Beverages:_____

_____

_____

What foods do you typically eat these days?

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Snacks:_____

_____

_____

Beverages:_____

_____

_____

Do you crave sugar, coffee, or cigarettes? Do you have any other major addictions?

_____

_____

_____

_____

What is the most important thing you should change about your diet to improve your health? _____

_____

_____

_____

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____