HEALTH QUESTIONNAIRE

Print, complete, scan and email to jennifer@inspirehealthyharmony.com prior to our first session.

First Name		Last Name	
Date of Birth		Phone Number	
Address (street, City, Zip)			
Email Address			
Height		Weight	
Marital Status		Spouse Name if Applicable	
Number of Children		Ages of Children:	
Health conditions / symptoms you are seeking support for			How long have you had these conditions or symptoms?
	1.		
	2.		
	3.		

Have you recently had any changes in

☐ Level of thirst	☐ Weight	☐ Appetite	☐ Food tolerance
☐ Urination	☐ Body/face shape	☐ Energy	☐ Stress level
☐ Breathing	☐ Personality behavior	☐ Bathroom issues	☐ Sleep
☐ Mood			

Your Health History

Have you now or in the past experienced any of the following? Choose all that apply.

Allergies	☐	Anxiety	☐
Arthritis	☐	Asthma	☐
Autoimmune	☐	Cancer	☐
Diabetes	☐	Depression	☐
Dementia	☐	Drug/alcohol dependence	☐
Ear/eye/nose/throat problems	☐	Eczema/skin conditions	☐
Epilepsy	☐	Frequent illness	☐
High blood pressure	☐	Gastrointestinal disorders	☐
Osteoporosis	☐	Heart Conditions	☐
Stomach ulcers	☐	Menstrual/menopause problems	☐
Stroke	☐	Sleep problems	☐
Urinary tract conditions	☐	Thyroid problems	☐

Other diagnosed conditions:

_____

_____

_____

Gut Health

	Do you experience any of the following?	Please provide details of any which occur regularly
☐	Abdominal bloating	
☐	Acid reflux	
☐	Bloating after meals	
☐	Burning pains in stomach and throat	
☐	White coating on tongue	
☐	Constipation	
☐	Diarrhea	
☐	Gas	
☐	Irritable bowel syndrome or other GI disorders	
☐	Not eliminating on a daily basis	
☐	Nausea and/or vomiting	

Female Only: please indicate if monthly menstruation is present: ☐ Yes ☐ No

Are you prescribed hormonal contraception or hormone replacement therapy? Please provide drug names

_____

Additional menstrual information:

_____

Are you trying to conceive or currently pregnant?

_____

Surgical Procedures: Please provide details of any surgery and approximate dates.

_____

_____

_____

Prescribed Medicines: Please list all medications you are currently taking and include dose. This information is important to enable us to suggest safe and appropriate nutritional supplements for you. **Please continue on a separate sheet if needed**.

Name of medication	What is it for?	Daily Dose

Over the counter medications used: Please list any medications, (ex: acetaminophen, ibuprofen, sleep aids) that you take on a regular or frequent basis.

Name of over the counter medications	What is it for?	Daily Dose

Supplements: Please list all supplements that you are taking **currently** (ex: multi-vitamin, probiotic).

Name of supplements	What is it for?	Daily Dose

Please list any recently **discontinued medications or supplements**?

_____

_____

_____

Family Medical History: Please provide details below of family health conditions (ex: Alzheimer's, Arthritis, Blood pressure, Dementia, Diabetes, Heart disease, Lung disease, Osteoporosis, Parkinson's disease, Stroke, Cancer, Auto immune disease)

Parents _____

_____

Grandparents _____

_____

Brothers/Sisters _____

_____

Have you had any recent bloodwork done? Can you provide a copy of the results? (please attach)

Be prepared to answer the following questions during our coaching session:

- What is your personal definition of health?
- What does good health look like and feel like for you?
- What would your daily life look like if you were healthy and feeling good?
- What could you accomplish if you were healthy?
- Why did you decide to make a change and begin a health journey?
- How motivated are you on a scale from 1-10?

Disclaimer: By completing this Health Questionnaire, you are disclosing your personal, private health information. This information enables Healthy Harmony to gain a deeper understanding into your health history. It is not meant to diagnose a medical condition. Please know that your information will be kept private and confidential. Coaching Sessions are for education and encouragement purposes only and it is not a substitute for medical advice from your physician.