

# Obstacle Identification

Print, complete, scan and email to [jennifer@inspirehealthyharmony.com](mailto:jennifer@inspirehealthyharmony.com) prior to our first session.

First Name		Last Name	
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There are many obstacles to balancing the body and achieving a healthier lifestyle. This identification process is designed to help recognize the barriers and obstacles that have held you back in the past.

## Physical Obstacles

Consider your personal health history. What are your current disease diagnoses? Has your doctor ever told you that you have Diabetes, Heart Disease, Auto Immune Disease, Fatty Liver Disease, Hormone Imbalance, Metabolic Syndrome, Thyroid Insufficiency, Adrenal Fatigue, Nutrient Deficiency, Leaky Gut, Candida Yeast Overgrowth, Blood Sugar Imbalance, Insulin Resistance, High levels of Inflammation. **Circle any of the above.**

Have you been told that you have food allergies? Corn, Dairy, Wheat, Gluten, Soy, Nut, Shellfish, Egg. **Circle all that apply.**

Do you currently take prescription and/or over the counter medication? Yes No  
Medications are foreign to the body. Therefore the body does not know what to do with them. This is a common obstacle to getting a body balanced.

Do you currently suffer from an injury or physical limitation that limits or hinders your ability to exercise? Yes No If yes, please explain \_\_\_\_\_

Do you find that it is difficult to lose weight even when adopting healthier eating habits and exercising? Yes No

Do you struggle with bathroom issues? (Diarrhea and/or Constipation) Yes No  
Are you eliminating on a daily basis? Yes No

Do you live or work in a toxic environment? (ex. work around chemicals, live with smoker) Yes No

## Behavioral Obstacles

Do you have a tendency to overeat? Yes No

Are a majority of your meals from a restaurant or fast food establishment? Yes No

Are most of the foods in your refrigerator and pantry processed foods? Yes No

Do you find that you are often hungry and have a large appetite? Yes No

Do you often skip meals and “make up for it” at the next meal? Yes No

Do you find yourself overwhelmed at choosing healthy foods and knowing what to choose? Yes No

Do you struggle with not getting enough sleep at night? Yes No

Do you drink enough water during the day? (Goal is half your body weight in ounces) Yes No

Are most of your beverages loaded with sugar and/or artificial sweeteners? Yes No

Do you drink alcohol? Yes No

Do you view alcohol as a means to help you relax and unwind? Yes No

Do you feel like you have become too dependent on alcohol? Yes No

Do you often feel stressed out and overwhelmed? Yes No

How or if you currently manage that stress? \_\_\_\_\_

Do you find it very challenging to take a comprehensive approach to wellness? Yes No

Do you lead an inactive lifestyle? Yes No

Are you easily affected at the planning aspect of maintaining a healthy lifestyle? Yes No  
(Example....planning out healthy meals and scheduling exercise)

Looking at the concept of moderation; can you handle moderation or do you do better with a strict approach? **Circle either moderation or strict.**

### **Mental and Emotional Obstacles**

Did you grow up with an unhealthy relationship with food? Yes No

Consider being forced to eat everything on your plate and also being raised in a poor environment where you did not know when you would eat again

Have you ever been diagnosed with an eating disorder? Yes No

As a child, were you considered overweight and told that you needed to lose weight? Yes No

Have you ever been made fun of because of your weight status? Yes No

Emotional eating - Do you find yourself eating when you are upset, depressed, anxious or angry?  
Yes No

Do you eat certain foods in secret and later feel guilty about eating those foods? Yes No

Do you have a "diet mentality?" Have you tried many diets or often think "I will start on this date?"  
Yes No

Do you suffer from depression or anxiety? Yes No

Are you currently on medication for this? Yes No

Do you have unrealistic expectations on your body shape and size? Yes No

Do you often feel shame, guilt and defeat when looking at your personal health history and weight status? Yes No

Do you feel overwhelmed and defeated when trying to adopt a healthier lifestyle? Yes No

Do you suffer from lack of motivation to get started with healthy changes? Yes No

Do you "think" about what you eat? Yes No

Do you have a lack of mindfulness about your current nutrition habits? Yes No

Are you impaired by a negative mental mindset? Yes No

Do you feel like you have specific fears that hold you back from living life to the fullest? Yes No

Do you struggle with low self-esteem? Yes No

Do you commonly hold a "mask in place" to hide what you are really struggling with inside? Yes No

### **Family and Social Obstacles**

Did you grow up in a home where good nutrition and health habits were discussed and encouraged? Yes No

When growing up, were you encouraged to eat fruits and vegetables? Yes No

Was weight status and dieting often discussed in your childhood home? Yes No

Are you responsible for food purchase and meal preparation in your home? Yes No

How does your spouse feel about a healthy lifestyle? \_\_\_\_\_

Is your spouse supportive of your efforts to get healthy? Yes No

Do you feel like your immediate family or extended family attempts to sabotage your efforts in adopting a healthier lifestyle? Yes No

Have you ever tried to improve your health with another individual or in a group? Yes No

Does your social circle have a "healthy" mindset? Yes No

Could your social circle be described as positive or negative? **(Circle Positive or Negative)**

What is your favorite thing to do with your family? \_\_\_\_\_

What do you like to do when you spend time with friends? \_\_\_\_\_

### **Spiritual Obstacles**

Do you view yourself as God views you? Yes No

Do you regularly spend quiet time studying His word? Yes No

Do you pray on a daily basis? Yes No

Do you view your health as something else on your To Do list? Yes No

Does your health limit you or hold you back from doing what God has called you to do? Yes No

### **Educational Obstacles**

Have you ever received any type of health education? Yes No

Where do you typically look for health and wellness information? \_\_\_\_\_

Would you describe yourself as "confused" when it comes to knowing what foods are healthy?  
Yes No

Does health information of any sort overwhelm you? Yes No

Do you get overwhelmed when looking at health information? Yes No

Do you take an All or Nothing approach? **Circle either All or Nothing.**

Do you find that the health information out there is confusing and conflicting? Yes No

Do you need a simple approach to adopting a healthy lifestyle? Yes No

### **Financial Obstacles**

Are there financial limitations when it comes to purchasing healthy foods or buying other items that promote a healthy lifestyle? Yes No

Consider your food budget and current grocery list. What items are you including on a weekly basis that are unhealthy and add to the overall cost? \_\_\_\_\_

Is financial debt a factor in your overall stress level? Yes No

Do you have good health insurance coverage? Yes No

Are you spending money on prescription medications, over the counter medications and doctor co-pays? Yes No

Do you look at money spent on improving your health as an investment? Yes No

**Disclaimer:** By completing the Obstacle Assessment, 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 are not a substitute for medical advice from your physician.