Health Thyme
TRANSFORM YOUR HEALTH

SENIOR HEALTH HISTORY

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

PERSONAL

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 6 Months ago: _____ Weight 1 Year ago: _____

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

SOCIAL

Relationship Status: _____

Where do you live? _____

Do you have grandchildren? _____ Do you have pets? _____

What is your occupation: _____ How many hours do you work per week? _____

What is your retirement plan? _____

GENERAL HEALTH

What are your main health concerns? _____

_____

_____

Any other concerns and/or goals? _____

_____

_____

SENIOR HEALTH HISTORY

GENERAL HEALTH (Continued)

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? _____

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? _____

_____

What is your energy like? _____

Do you still feel independent? _____

Are you part of a community? _____

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? _____

SENIOR HEALTH HISTORY

FOOD (Continued)

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquid

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquid

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?