



(Men's Health Survey): Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____ Birth Place: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ if so, what? _____

SOCIAL INFORMATION

Relationship status: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

Please list your main health concerns: _____

Other concerns and/or goals? _____

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

Any serious illnesses/hospitalizations/injuries? _____

HEALTH INFORMATION (continued)

How is/was the health of your mother? _____

How is/was the health of your father? _____



What is your ancestry? _____ What blood type are you? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

Any healers, helpers, or therapies with which you are involved? _____

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

FOOD INFORMATION

What foods did you eat often as a child?

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|-----------|-------|--------|--------|---------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

What is your food like these days?

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|-----------|-------|--------|--------|---------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |



Will family and/or 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 do you get the rest from? _____

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

The most important thing I should do to improve my health is: _____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

Please complete and email this form to Ennis@TwoRiverHealth.com