

First name: _____ Last name: _____ Sex: Male Female

My top 3 concerns today about my health (1) _____ (2) _____ (3) _____

How did you hear about the Rejuvenation 21 Plan? _____

Date of Birth: ____ - ____ - ____ Age: _____ City & State born: _____

Phone: _____ (Home) _____ (Work) _____ (Cell) _____

Street _____ City _____ State _____ Zip _____

Number of pounds overweight as seen by yourself? _____

Every day I consume: (1 serving = 1 cup) (Please circle item or check box)

Servings of fresh fruits 5 or more 4 3 2 1 0

Servings of vegetables, salad, and green foods.. 5 or more 4 3 2 1 0

Servings of water (8 oz. cups)..... 5 or more 4 3 2 1 0

Servings of fried foods per day..... 5 or more 4 3 2 1 0

Number of bowel movements per day..... Diarrhea 4 3 2 1 0 Constipated

Number of hours of sleep per night..... 8+ or more 7 6 5 4 3 2 1 0

I usually use the following oils when I cook: Coconut, Olive, Canola, Vegetable, Shortening

I use the following to balance the flora in my gut: Acidophilus, Probiotics, Kefir, Yogurt How often? _____

I use the following sweeteners:

White Sugar, Brown Sugar, Splenda, Sweet-N-Lo, Honey, Stevia, Xylitol How often? _____

I have some of the following symptoms (Check all that apply)

- I suffer from panic attacks
- Trouble staying focused on my job while working
- I am often told that I am too serious or intense
- I have yellow or thick big toe nails
- Feel dizzy upon standing
- Short term memory loss/ brain fog
- Legs jerk while sleeping
- Low sex drive
- I sometimes wake up between 3 and 4am
- I have dark circles under my eyes
- I frequently have nightmares
- Feel worse after exercising, not energized
- I consistently have low blood pressure
- Light sleeper and/or suffer from insomnia
- Cold hands or feet
- My hair is falling out or thinning
- I have an energy drop in the afternoon
- I have dry skin
- My pulse is <70 or > 90
- I have missing patches of skin pigmentation
- I have muscle aches or cramps often
- Family history of breast cancer
- Frequent headaches
- My periods are irregular or very heavy
- I have plantar fasciitis/pain on soles of feet
- I nod off easily or have sleep apnea
- Infertility problems
- Muscle aches
- Joint pain
- Red eyes
- Poor vision
- Tremors of hands
- Bell's palsy
- Insomnia
- Difficulty driving at night
- I have heart palpitations
- Bladder irritation
- Bright light sensitivity
- I have heart palpitations
- Frequent anxiety
- Feel exhausted all the time/ tired for no reason
- Allergies
- I often feel my best after 6 p.m.
- I am often edgy or pessimistic
- I have a hard time losing weight
- I have indigestion or burning in my stomach after eating
- I crave chocolate or salty foods (circle which)
- I have elevated triglycerides
- I have trouble getting up and out of bed in the morning
- I often suffer from headaches, migraines, and muscles cramps
- I tend to be cold most of the time
- My nose runs frequently
- When I gain weight it is usually around my waist
- I have a history of "yo-yo" dieting
- I have a voice strain
- My eyebrows are thinning
- I often feel my heart pounding
- I have had panic or anxiety attacks in the past
- I have dark patches or rough skin on my elbows
- My tongue is wide
- I have frequently taken birth control pills or Aspirin in the past
- I have had problems with depression
- I have elevated cholesterol
- I have ringing in my ears, carpal tunnel, or canker sores
- I have vertical ridges on my nails or my nails crack and/or peel

Retinal disease Bell's palsy Irritable bowel syndrome Unexplained rash after tick or spider bite
Prostate problems (VPH) Impotence Frequent Urination Bladder irritation
History of ulcers or gastritis Frequent heartburn or indigestion with nausea and pain Acid reflux after eating
Frequent use of antacids Stomach pain that is relieved by eating Frequent belching Arm, shoulder, or neck pain

- Foul odor to breath and/or white film on tongue Unusually large appetite abdominal gas
- Do you have premenstrual breast tenderness Do you have premenstrual mood swings
 Do you have premenstrual fluid retention and weight gain Premenstrual headaches
 Migraine headaches Severe menstrual cramps
 Do you have heavy periods with clotting Do you have irregular menstrual cycles
 Are you or have you taken any estrogen support Do you have uterine fibroids
 Do you have endometriosis Have you had problems with infertility
 Have you had a miscarriage Started menstruation before age 13
 Do you have a decreased libido Do you have anxiety or panic attacks
- Right shoulder pain or pain by scapula Do you have a belching problem Gallbladder issues

I have had the health conditions I checked below.

Frequent Constipation High cholesterol Bypass surgery Stroke Asthma
Pacemaker Seizures Heart failure High blood pressure Cancer
Chronic pain_____ (where) Lung disease Depression Frequent headaches Arthritis
Heart problems Diabetes:_____ Type 1 or ___ Type 2 (Age at onset___) I use insulin ___yes ___no
Surgeries (date):_____

Tobacco Use: Never Quit _____ years ago Current user Type of tobacco used _____

What type of estrogen support have you taken?

Ideally, how often would you like to be contacted by your weight loss coach?

- Daily Every couple of days Every three-five days I will contact the coach when I have questions

Would you like your coach to text message you? If yes, what number do you receive text messages?
(_____)

Would you like your coach to e-mail you? If yes, what e-mail address do you prefer?

How much soda and diet soda do you drink in a day? _____

How many alcoholic beverages do you consume daily? _____

How much white bread and sugar do you consume daily? _____

Typically, what color are your bowel movements? _____

Do you see bubbles in your urine when you urinate? _____

In the next six weeks, do you have any special occasions coming up (vacations, birthdays, anniversaries, etc.) If yes, what type of occasion and when? _____

Are you comfortable with cooking and preparing your own meals? _____

Do you take any diuretics? _____

When was your last menstrual cycle? _____

Are you on birth control? _____

Have you had an organ transplant? _____

Do you have gout? _____

Are you pregnant or nursing? _____

Do you have cancer and/or are you receiving cancer treatments? _____

Are you taking any steroid medications? _____

Medicine/vitamins/herbs: I take the following medications _____

I regularly take these **over-the-counter drugs, herbs, vitamins:** -

I understand that I am receiving wellness coaching for weight loss. I agree that I am receiving suggestions to improve my health. It is my choice and responsibility to improve my health. I understand these are only suggestions and I have not received any guarantees regarding these suggestions.

Signature

Date

Coach