Universal Wellness Associates

Holistic Nutrition Wellness Coaching
Your Resource for Healthy Eating and Healthy Living

Health Evaluation Profile

Name_____**Date**_____

Address_____**City**_____**State**_____**Zip**_____

Phone (d)_____**(eve)**_____**E-mail**_____

Height_____**Weight**_____**Body Frame**____**Blood type**____**Birthdate**_____

Children?_____**How many?**_____**Women: Pregnancy: Easy or difficult?**_____

Occupation_____

Exercise/Recreation_____

Health Concerns

List your five major health concerns at this time_____

Describe the onset and occurrence of health problems in detail: (use a separate sheet if necessary) _____

8005 Sacramento Street Fair Oaks, Ca. 95628 (916) 961-0676 Fax: 961-0624

Health Evaluation Profile

How have you dealt with these concerns in the past (doctors, self-care, etc.)?

List any medicine or supplements you are currently taking for these or other health problems as well as for improving and maintaining health status.

Have any other family members had similar problems? (describe)

Family health history: Any other health issues? (diabetes, heart disease, thyroid disease, cancer, etc.)

Condition of hair: (thinning, losing any, dry, etc.)

Nails: (white spots, ridges, cracks, thin, break easily, strong, grow easily, etc.

Sleep: fall asleep, stay asleep, wake up during the night, insomnia, wake up early, sleep short hours, etc.

Health Evaluation Profile

How would you rate your levels of stress in the following areas: (1-10 with ten indicating high levels of stress)

a. **Work**_____

b. **Family**_____

c. **Relationships**_____

d. **Environmental (allergies and toxic exposures)**_____

e. **Financial** _____

f. **Other (describe)**_____

How has your diet changed in relationship to your health concerns? (special diets, etc.) _____
_____
_____
_____
_____
_____
_____
_____

Family eating habits: What was your diet like as a child? _____
_____
_____
_____
_____

Describe the foods you eat (comfort foods) when you are:

a.	**Hungry**	**c.**	**Lonely**	**e.**	**Depressed**
b.	**Angry**	**d.**	**Tired**	**f.**	**Celebrating**

Readiness Assessment
Rate on a scale of 5 (very willing) to 1 (not willing):

1. In order to improve your health, how willing are you to:

- Significantly modify your diet __5 __4 __3 __2 __1
- Take several nutritional supplements a day __5 __4 __3 __2 __1

  Keep a record of everything you eat each day __5 __4 __3 __2 __1
- Modify your lifestyle (e.g. work demands, sleep habits) __5 __4 __3 __2 __1
- Practice a relaxation technique __5 __4 __3 __2 __1
- Engage in regular physical activity __5 __4 __3 __2 __1
- Have periodic lab tests to assess your progress __5 __4 __3 __2 __1

Dental History
Did you remove mercury amalgams/fillings in past?

- __Yes
- __No

If yes, how long ago? _____

Other types of dental work and dental issues:

__Gold fillings
__Root canals
__Implants
__Tooth pain
__Bleeding gums
__Bad breath/halitosis
__Gingivitis
__Problems chewing
__TMJ
__Other types of fillings: composite, porcelain

Congratulations on taking this step forward to achieving your health goals! I look forward to working together with you on your path to wellness.

Linda Clark, MA, CNC