Fresh Start Health History Form

Please fill out this form honestly and be specific as possible. I will be able to help you know more about you.

Name : _____ Age: _____ Height: _____ Weight current: _____
Address: _____
City: _____ State: _____ Zip: _____ Gender: M or F
Email: _____ Text/Phone Number _____
Health History:
Do you know your blood type? _____
Do you currently have any heart issues: _____ Y or N
(Chest pain, Lightheadedness, Stroke history, Fainting, etc)
Have you been diagnosed with High Blood Pressure? _____ Y or N
Have you been diagnosed with High Cholesterol ? _____Y or N
Do you have any diagnosed health conditions currently? _____
Do you have difficulty with physical exercise? Explain: _____
Any recent surgeries? _____
Are you pregnant or trying to get pregnant? _____
Any breathing issues or lung problems? _____ Y or N
Any Muscle, joint, or back disorders or previous injury still affecting you? Y or N
_____
Have you been diagnosed as a Diabetic? _____ Y or N
Do you have a thyroid disorder ? _____ Y or N
Do you currently smoke or use tobacco products? _____ Y or N
Do you have a history of health problems in your family? Explain: _____
_____
_____

Are you on any current Medications/Prescriptions: Y or N
_____
_____
_____
Are you taking any supplements/ herbals? Y or N
_____
_____
_____
What is your current Fitness Regimen (Time of Day, activity, intensity)
_____
Have you ever used Beachbody Products Before? Y or N
If so, it is required to switch to Jen Thompson as your coach. Coach ID 447681
Email Jeneration_fitness@yahoo.com

Current Nutrition: List in detail what a typical day would consist of

Time Items

Breakfast_____
_____

Snack: _____

Lunch: _____
_____
_____

Snack: _____
_____

DInner: _____
_____
_____

Evening Snack : _____

How much water do you normally drink in a day? _____
Do you drink calories: _____
Do you drink alcohol? _____

Circle Any that relate to you:

Do you have a sweet tooth, salt craving, constantly hungry, no appetite ?
Do you feel you need to work on portions, emotional control, meal planning, reading labels?
Do you go out to eat a lot? Y or N if yes, how often?_____
Do you pack your lunch ? Y or N if yes, how often? _____

What other diet plans have you tried in the past? _____
_____
_____

What is your main reason for wanting this Fresh Start Program? _____
_____
_____

What is the best time/day of week to do your initial consult with Coach Jen?
_____

What's Next?

You will receive a message from Jen to schedule your 60 minute goal setting consultation!