4TH DISCIPLINE COACHING

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Patient Medical History

The health information you provide in this booklet will never be disclosed to outside parties. It will be used to assist me as your dietitian/nutritionist and coach in developing your unique program.

Primary Care Doctor

Name: _____ Phone:_____ Fax:_____

Specialist Doctor

Name: _____ Phone:_____ Fax:_____

Patient Name

First**:** _____ Last **:**_____

Parent Name: _____

Street Address: _____City: _____ State: ____

Zip: _____ Email Address: _____

Preferred Contact Phone: (_____)_____ Best Hours To Call: _____

Alternate Phone 1: (_____)_____ Best Hours To Call: _____

Alternate Phone 2: (_____)_____ Best Hours To Call: _____

Symptom Survey

Date:	Client Name:	Client/Parent Signature (if < 18):

Please fill in the following form completely. Score every symptom based on your experience over the last 30 days. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed.

SCALE OF SYMPTOM POINTS:

●○○○○ = 0 = Did Not Suffer From This Ever or Almost Ever
○●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
○○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
○○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**
○○○○● **= 4 =** Suffered FREQUENTLY and symptom **was severe**

CONSTITUTIONAL
○○○○○ Fatigue (sluggish, tired)
○○○○○ Hyperactive (nervous energy)
○○○○○ Restless (can't relax/sit still)
○○○○○ Sleepiness During Day
○○○○○ Insomnia at Night
○○○○○ Malaise (Feel Lousy)
_____ TOTAL (0-24)

EMOTIONAL/MENTAL
○○○○○ Depression
○○○○○ Anxiety
○○○○○ Mood Swings
○○○○○ Irritability
○○○○○ Forgetfulness
○○○○○ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS
○○○○○ Headache (any kind)
○○○○○ Earache
○○○○○ Ear Infection
○○○○○ Ringing in Ear
○○○○○ Itchy Ears
○○○○○ Discharge From Ears
_____ TOTAL (0-24)

SKIN
○○○○○ Blemishes, Acne
○○○○○ Rashes, Hives
○○○○○ Eczema
○○○○○ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS
○○○○○ Post Nasal Drip
○○○○○ Sinus Pain
○○○○○ Runny Nose
○○○○○ Stuffy Nose
○○○○○ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT
○○○○○ Sore Throat
○○○○○ Swollen Throat
○○○○○ Swelling of Lips/Tongue
○○○○○ Gagging/Throat Clearing
○○○○○ Canker Sores
_____ TOTAL (0-20)

LUNGS
○○○○○ Wheezing
○○○○○ Chest Congestion
○○○○○ Dry Cough
○○○○○ Wet Cough
_____ TOTAL (0-16)

EYES
○○○○○ Red or Swollen Eyes
○○○○○ Watery Eyes
○○○○○ Itchy Eyes
○○○○○ Dark Circles" or "Bags"
_____ TOTAL (0-16)

GENITOURINARY
○○○○○ Increased Urinary Frequency
○○○○○ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL
○○○○○ Joint Pains/Aching
○○○○○ Stiff Joints
○○○○○ Muscle Aches
○○○○○ Stiff Muscles
_____ TOTAL (0-16)

CARDIOVASCULAR
○○○○○ Irregular Heartbeat
○○○○○ High Blood Pressure
_____ TOTAL (0-8)

DIGESTIVE
○○○○○ Heartburn/Reflux
○○○○○ Stomach Pains/Cramps
○○○○○ Intestinal Pains/Cramps
○○○○○ Constipation
○○○○○ Diarrhea
○○○○○ Bloating Sensation
○○○○○ Gas (of Any Kind)
○○○○○ Nausea, Vomiting
○○○○○ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT
_____ **Record Actual Weight**
○○○○○ Fluctuating Weight
○○○○○ Food Cravings
○○○○○ Water Retention
○○○○○ Binge Eating or Drinking
○○○○○ Purging (all methods)
_____ TOTAL (0-20)

Health History Questionnaire

The Health History Questionnaire section supplements information obtained in your Symptom Survey with past medical problems and treatments. Please answer all questions completely and accurately.

Name:		Date of Birth:	
Sex: [ ] Male [ ] Female	Height:	Weight:	Blood Pressure: /
Marital Status:		Occupation:	

List Your Main Health Complaints (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	

Surgical History (Please list all surgeries)

1.	2.	3.

Circle (Or Write In) All Medical Conditions You Have Been Previously Diagnosed With

Arthritis, Rheumatoid	Crohn's Disease	Hypoglycemia	Fructose Intolerance
Arthritis, Osteo	Depression	Interstitial Cystitis	Other:
Asthma	Diabetes	Irritable Bowel Syndrome	Other:
Attention Deficit Disorder	Eczema	Lactose Intolerance	Other:
Celiac Disease	Gastroesophageal Reflux	Migraine	Other:
Chronic Fatigue Syndrome	Hives	Rhinitis	Other:
Colitis	Hypertension	Ulcerative Colitis	Other:

List All Medications You Currently Take Regularly OR As Needed (Prescription & OTC)

Drug	Dosage	# Times Per Day	Start Date

Allergy History

Does Anyone In Your Family Have Allergies? [ ] Yes [ ] No

If Yes: [ ] Parent [ ] Sibling [ ] Other Blood Relative:

Training Preferences & History	
Do you compete on a regular basis? ❑Yes ❑ No Are you a lifelong athlete? ❑Yes ❑ No Sport(s):	During a typical week how many workouts will you do? ❑ 0 ❑ 1-3 ❑4-5 ❑ 6-7 ❑ >7
Do you usually workout in the ❑ am ❑ pm ❑ varies	Do you workout or train more than once per day? ❑ Yes ❑ No
Do you prefer to workout ❑ alone ❑ with friends ❑ varies	How many days per week do you train 2x per day? _____
How long are your <u>typical</u> training sessions? ❑ < 1 hour ❑ 1-2 hours ❑ 2 hours	
How long is your longest training session? ❑ < 1 hour ❑ 1-2 hours ❑ 2 hours	
How much time do you have to train or workout on weekdays?	
How much time do you have to train or workout on weekends?	
Do you have any days of the week that must be excluded from training?	
Other Considerations:	

Program Goals
What Training and Nutrition Goals do you want to accomplish? Whether your aim is to decrease the frequency or severity of specific symptoms, complete a race or event, or to increase speed, energy and general wellness, I will work with you to design a plan that will help you achieve those goals. The first step is to write down your goals and then discuss them with me so I can develop your personalized plan.
1.
2.
3.
4.
5.