



General Information Section:

First Name _____ Last Name _____ Middle Initial _____

E-Mail Address _____

DOB ____ / ____ / ____ Age ____ Married Single Divorced Widowed Other _____

Occupation _____ Cell Phone _____

Goal Selection:

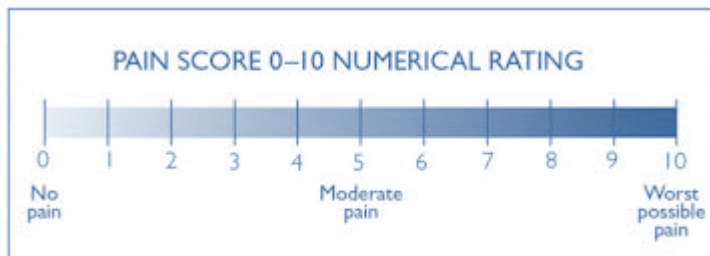
I am seeking Health Coaching for _____

My goals are _____

Current Medical History

Do you have any current concerns or complaints? Yes No If yes, please describe _____

Do you have any pain? Yes No If yes, please rate your pain level on a scale from 0 to 10: _____



Are you receiving any other services or treatments? Yes No If yes, please describe _____

Allergies: _____

Past Medical History:

Past Surgical History: Please list dates.



Past Medical History:

Please Check All That Apply To **You**.

- | | | | |
|------------------------|--|---------------------------------|--|
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Joint Replacement | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Dysfunction | <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Hyperglycemia/
Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No |
| Heart Disease | <input type="radio"/> Yes <input type="radio"/> No | Dizziness/Fainting | <input type="radio"/> Yes <input type="radio"/> No |
| Angina/Chest Pain | <input type="radio"/> Yes <input type="radio"/> No | Constipation | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke/TIA | <input type="radio"/> Yes <input type="radio"/> No | Incontinence | <input type="radio"/> Yes <input type="radio"/> No |
| Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Irritable Bowel
Syndrome | <input type="radio"/> Yes <input type="radio"/> No |
| Osteoarthritis | <input type="radio"/> Yes <input type="radio"/> No | Sexual/Physical Abuse | <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatoid Arthritis | <input type="radio"/> Yes <input type="radio"/> No | Sexually Transmitted
Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Reflux/GERD | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Headaches/Migraines | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis | <input type="radio"/> Yes <input type="radio"/> No |
| Kidney Disease | <input type="radio"/> Yes <input type="radio"/> No | Alcoholism/Drug
Problems | <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No | Smoking History | <input type="radio"/> Yes <input type="radio"/> No |
| Ulcers | <input type="radio"/> Yes <input type="radio"/> No | Vision Loss/Problems | <input type="radio"/> Yes <input type="radio"/> No |
| Contagious Diseases | <input type="radio"/> Yes <input type="radio"/> No | Latex Allergy | <input type="radio"/> Yes <input type="radio"/> No |
| Seizures | <input type="radio"/> Yes <input type="radio"/> No | Insomnia | <input type="radio"/> Yes <input type="radio"/> No |
| Depression/Anxiety | <input type="radio"/> Yes <input type="radio"/> No | Hearing Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Chronic Fatigue | <input type="radio"/> Yes <input type="radio"/> No | Currently Pregnant | <input type="radio"/> Yes <input type="radio"/> No |
| Fibromyalgia | <input type="radio"/> Yes <input type="radio"/> No | | |
| Head Injury/Concussion | <input type="radio"/> Yes <input type="radio"/> No | | |
| Multiple Sclerosis | <input type="radio"/> Yes <input type="radio"/> No | | |
| Back Pain | <input type="radio"/> Yes <input type="radio"/> No | | |
| Pelvic Pain | <input type="radio"/> Yes <input type="radio"/> No | | |

Acknowledgement of Receipt of Notice of Privacy Practices:

Signature: I, _____, acknowledge that I have received the Notice of Privacy Practices for Pelvic Health Matters in Coaching. I have had full opportunity to read or have read to me and consider the contents. I consent to the use and disclosure of your Notice of Privacy Practices.

Privacy Authorization: Your Rights:

When it comes to your protected health information you have the right to request confidential communications or that communication be made by alternative means.

Please indicate your communication preferences:

You may contact me by: cell home work.

Leave a message: with family text voice mail email.

I am happy to include you in our email Newsletter, Special Events & Educational Events.

Please let me know if you do not wish to subscribe. Yes, include me No, I do not wish to subscribe