**Health Assessment for \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**A picture containing schematic

Description automatically generated

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|  | **Question** | **Answer** |
| **1** | **List ALL of your concerns about your health, fitness, and body.** |  |
| **2** | **Out of all of the above concerns, which 3 feel most important/urgent?** |  |
| **3** | **Why – what is the benefit, reward or pleasure you will gain by improving your health in these 3 areas?** |  |
| **4** | **What will it cost you in the long term if you don’t make these changes?** |  |
| **5** | **What short term pain, discomfort or inconvenience will you experience if you try to make these changes now?** |  |
| **6** | **What are the benefits of staying just as you are? How does your current state of health serve you?** |  |
| **7** | **What are your top 3 health goals for the next 4 weeks?** |  |
| **8** | **What are you prepared to do to achieve your goals?** |  |
| **9** | **What have you tried in the past to change your health habits?** |  |
| **10** | **Which of those things worked well for you? Would you try it again?** |  |
| **11** | **Which of those things didn’t work well for you? What could you do differently to make it more effective?** |  |
| **12** | **If you were going to make changes to your habits, what might those be?** |  |
| **13** | **What are you not ready or willing to do and why?** |  |
| **14** | **On a scale of 1(poor) to 10 (excellent), rate your overall eating/nutrition habits?** |  |
| **15** | **How many portions of fruit and vegetables do you have in a day?** |  |
| **16** | **How many glasses of water do you drink in a day?** |  |
| **17** | **How often do you cook at home or eat out/get takeaway?** |  |
| **18** | **Do you have any suspected or diagnosed food allergies or intolerances? How do they affect you? Do you still consume those foods regardless?** |  |
| **19** | **How often do you skip meals or go a long time without eating?** |  |
| **20** | **How often do you eat late at night?** |  |
| **21** | **How much sugar do you consume daily – high/medium/low:** |  |
| **22** | **How many units of alcohol do you consume in a day/week? How does it affect your health?** |  |
| **23** | **How many cigarettes do you smoke in a day/week? How does it affect your health?** |  |
| **24** | **Do you take any recreational drugs, if so what and how much? How does it affect your health?** |  |
| **25** | **Are you regularly active in sports / exercise and if so how many hours a week? How does it affect your health?** |  |
| **26** | **How many hours per week do you engage in other types of physical activity (e.g., housework, walking to or from work, home repairs, moving at work, gardening)?** |  |
| **27** | **Do you suffer from digestion problems? Are your bowel movements regular?** |  |
| **28** | **Have you been diagnosed (currently or in the past) with any significant medical condition(s) and / or injuries?** |  |
| **29** | **Are you taking any medications (over-the-counter or prescription) for them? Are you experiencing any side effects?** |  |
| **30** | **Where in your body do you experience pain? Score each pain point from 1 = low to 10 = high:** |  |
| **31** | **In an average week how many hours do you spend:** | * In paid employment\_\_ * studying\_\_\_\_ * travelling\_\_\_\_ * volunteering\_\_\_ * caring for others\_\_\_ * housework and errands \_\_\_\_\_ |
| **32** | **Given all the demands of your life, on a scale of 1 (low) to (10 high), what is your typical stress level on an average day?** |  |
| **33** | **On average, how many hours per night do you sleep?** |  |
| **34** | **How would you rate your quality of uninterrupted sleep?** |  |
| **35** | **What tends to make you feel stressed?** |  |
| **36** | **How do you normally cope with your stress? Do your current strategies help you bring stress levels down?** |  |
| **37** | **Do you take any medication for stress?** |  |
| **38** | **What do you do to relax and let go of the day?** |  |
| **39** | **Do you take any vitamins or supplements?** |  |
| **40** | **Are you seeing your period regularly or experiencing menopause or pre-menopause symptoms?** |  |
| **41** | **Do you take any medication for your period, menopause or contraception? Do you experience any side effects due to this?** |  |
| **42** | **Has there been any change in your sex drive?** |  |
| **43** | **Are there any other indicators of hormonal imbalance (e.g. brain fog, irritability, body aching, overheating).** |  |
| **44** | **Do you think you need to book an appointment with a GP or specialist to explore some of the health issues you have identified in this questionnaire?** |  |

**MONTHLY HEALTH GOALS FOR \_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| **Desired Outcome/Goal** | **Actions to take – what, how, when, support needed** |
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**Weekly Accountability System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Monthly Acton Plan Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**