**The Mind Body Questionnaire**

*This document has been designed as the first stage of your coaching process. As the client, the more information you can provide, the more your coach will be able to deliver the best service to help you achieve your goals.*

**Part 1: Your Contact Details** - Please complete where appropriate

Name:

D.O.B:

Address:

Today’s Date:

Email Address:

Mobile Number: Prefer text? Then check the box □

Work Number:

Home Number:

Please attach a headshot of yourself below:

**Instructions**

1. Create some time to focus on completing this form. Please fill out the form to the best of your ability. If you are unsure of anything, or of what answer to give, you can check with your coach on your first call.
2. Put yourself in a good state.
3. You are about to clarify and set your primary health outcome for your life. *Get excited!*
4. Your goals may change in time - this is fine, but do not spend your time trying to fix what is not perfect with what you have written. Accept that whatever you have done is perfect right now.
5. Now complete the remainder of the Questionnaire, remember to be detailed as possible.
6. Email this to me once you’re finished healwithmind@gmail.com.
7. Remember to keep a copy close at hand. It is a great idea to review it regularly and you will need to look back over what you have written prior to each coaching session.

**Part 2: You and Your Life Now**

1. What are you currently doing in your life/career/business?
2. List and describe the most important relationships in your personal life at this time? (e.g. partner, family, children, friends).
3. What do you enjoy? What are you passionate about?
4. What motivates and excites you?
5. What are the things in your life right now that you are most proud of, and most pleased and satisfied with?
6. What are the biggest frustrations, disappointments, challenges or failures that you are currently experiencing?
7. How long have you had these frustrations, disappointments, challenges or failures?
8. What have these cost you?

(Think of time, money, lost opportunities, relationships, health, etc. Please be specific.)

1. What has stopped you from overcoming your current frustrations, disappointments, challenges, or failures?
2. What will your current frustrations, disappointments, challenges or failures continue to cost you if you don’t overcome them?
3. Score each of these areas of your life out of 10.

* Health and Wellness ( )
* Relationships and Romance ( )
* Family and home life ( )
* Personal development ( )
* Career/Business ( )
* Finances ( )
* Success/Fulfilment ( )
* Contribution ( )

1. Thinking about the area of your life you identified above, please answer the following questions:
   1. What is the specific problem or issue in this area of your life?
   2. How do you know you have this problem?
   3. What have you done in the past to change this situation?
   4. How will you know when your obstacles have gone? What will you think and feel?
   5. When you have overcome your problem, what will you be able to do/ be that you can’t now?
   6. What resources do you have and what would help you to get what you want?
2. Please list your top 10 values in relation to your life. What is most important to you in the context of your life at this time?
3. What course have you completed so far in respect of educational courses, NLP, etc.?
4. What is your preferred representational system?

*Visual, auditory, kinaesthetic, or auditory digital*

(This is an optional question – if you are not sure, wait to speak with your coach during your first session.)

**Part 3: Primary Motivation and Grand Purpose**

1. What is your primary motivation for enrolling in and completing this health coaching?
2. What do you want to achieve from working with me?

(Think now, and consider…make this health outcome so big, so exciting that, when you achieve it, it would make your experience in coaching the most important and significant experience of your life.)

1. Why is this so important to you?

(What is the deep, driving reason for achieving your primary health outcome? Make this purpose statement so big and juicy that it inspires you, propels you forward and creates a total desire to succeed. Remember, include how this achievement will affect the lives of your loved ones, those around you and the planet as a whole.)

**Part 4: About YOUR coaching**

1. What are the top things/criteria you want in a coach?
2. Are there any special ways your coach can support you through this process?
3. For this process to be truly successful do you feel does your coach need to be/do?
4. For this process to be truly successful is there anything special that you need to be/do?

**Part 5: About Your Health Goals**

1. In 12 months, my health will be…?
2. Have you already set any health goals for yourself? If not, what has stopped you?
3. How have you captured those goals?
4. What are your most important lifetime goals?
5. What are your most important one-year goals?

**Part 6: In Summary**

1. What is your desired outcome for this coaching program?
2. How will you know you have achieved this outcome?
3. Please choose 1 health goal that you want to work on with your coach immediately.

**Part 7: Your Health Intake**

Height:

Weight:

Relationship status:

Divorced / Single / Widowed / Married / Living with Partner / Separated / Other

Occupation:

Physician:

Your main health concern:

When did this condition start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ago.

* 1. Heat makes it:

better/ no change / worse

* 1. Cold makes it:

better/ no change / worse

* 1. Damp weather:

better/ no change / worse

* 1. Exercise / Activity:

better/ no change / worse

**Your Health** **History**

Check any that apply below and write “in family” if there is family history with any illnesses below:

□ Cancer (types?)

□ Diabetes (types?)

□ Hepatitis

□ High Blood Pressure

□ Heart Disease

□ Stroke

□ Seizure Disorder

□ Thyroid Disease

□ Asthma

□ Pacemaker

□ Osteoporosis

□ Herpes

□ AIDS / HIV

□ Other STD

□ Rheumatic Fever

□ Alcoholism

□ Allergies (types?)

□ Mental Illness

□ Kidney Disease

□ Anaemia

**Your Health Habits**

Write your amount of each per week beside each listed below:

1. Coffee / Tea
2. Soda
3. Tobacco
4. Alcohol
5. Drugs

**Your Exercise**

Do you exercise regularly?

If so, what do you do and how often?

**Your Diet**

Do you have a special diet now or in the past?

(Vegetarian, vegan, raw, Atkins, etc.)

**Your Medications**

Please note what medications, herbs or supplements that you take regularly

**Your Injuries & Surgeries**

Please write out what happened to any area of your body and when it occurred (include dental issues)

**Your Temperature**

How warm/ cold you feel (not in degrees); relative to other people – do you wear more or less layers, etc.?

Check any below that are applicable and write details below:

□ Cold hands or feet

□ Chills

□ Cold in the bones

□ Areas of numbness

□ Thirst, no desire to drink

□ Absence of thirst

□ Excessive thirst

□ Night sweats

□ Unusual sweats – when and where on the body?

□ Hot hands, feet, chest

□ Hot flashes

□ Hot in afternoon

□ Hot at night

**Your Moisture**

How is your overall body moisture? (hair, skin, mouth, bowels, etc.) Check any that are applicable and write details below.

□ Dry skin

□ Dry hair

□ Dry eyes

□ Dry brittle nails

□ Dry mouth

□ Dry lips

□ Dry throat

□ Dry nose / nosebleeds

□ Edema / swelling

□ Rashes

□ Itching (where on your body?)

□ Dandruff

□ Oil skin

□ Oily hair

□ Pimples

□ Weight gain / loss

**Your Digestion**

□ BM: How often? \_\_\_ x’s/ each \_\_\_\_day?

□ Alternating diarrhoea & constipation (IBS)

□ Indigestion

□ Gas

□ Bloating

□ Belching

□ Poor appetite

□ Nausea / Vomiting

□ Bad Breath

□ Heartburn

□ Excessive hunger

□ Dry Stools

□ Difficult to pass

□ Tired after BM

**Your Energy**

□ Sudden energy drop / time of day: \_\_\_ am/ pm

□ Energy drop after eating

□ Fatigue

□ Dependence on caffeine / stimulants

□ Wired / ungrounded feeling

□ Body / Limbs feel heavy

□ Body / Limbs feel weak

□ Shortness of breath

□ Heart Palpitations

□ Blood pressure Hight / Low

□ Bleed / Bruise easy

□ Hard to Concentrate

□ Poor memory

□ Dizziness / Lightheaded

□ Headaches \_\_\_\_ x’s / week

**Your Sleep**

How many hours per night?

□ Difficulty falling asleep

□ Wake \_\_\_ x’s/ night at \_\_\_ am / pm

□ Wake to urinate – how often?

□ Disturbing dreams

□ Restless sleep

□ Not rested upon waking

**Your Emotions**

What emotions dominate your experience?

□ Anger

□ Irritability

□ Anxiety

□ Worry

□ Obsessive thinking

□ Sadness

□ Grief

□ Depression

□ Joy

□ Fear

□ Timid / Shy

□ Indecision

**Your Eyes, Ears, Nose, Throat**

□ Poor vision

□ Night Blindness

□ Red eyes

□ Itchy eyes

□ Spots in front of eyes

□ Sinus congestion

□ Phlegm

□ Poor hearing

□ Ringing in ears

□ Excess earwax

□ Sore throat

□ Dental problems

□ Mouth sores Cough

**Your Urine**

Fluid in = Fluid out? □ Y □ N

□ Decrease in flow

□ Dribbling

□ Difficulty starting / stopping

□ Incontinence

□ Kidney stones

□ Urgency to urinate

□ Frequent urination

□ Pain on urination

□ Burning sensation

□ Cloudy urine

□ Blood in urine

**Your Reproductive Organs** (if applicable)

Are you sexually active: □ Y □ N

□ Change of sexual drive

□ Erectile dysfunction

□ Premature ejaculation

□ Sores on genitals

□ Discharge

□ Prostate disease

□ Genital pain

□ Jock itch

□ Vasectomy

□ Hernia

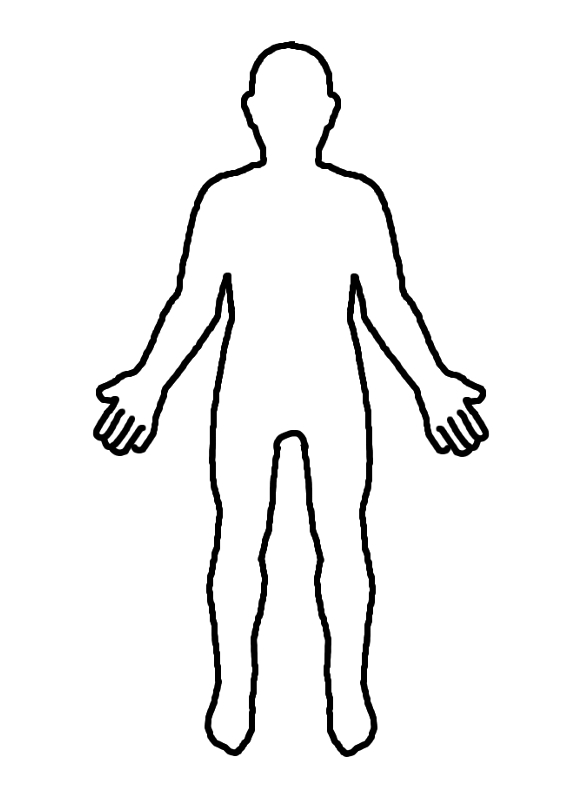
□ Haemorrhoids

Are you receiving government benefits or is someone supporting you? □Y □N

If yes, are you aware that this could cause a conflict-of-interest to your healing program? Consult with your coach.

**Identification of Pain or Discomfort in Your Physical Body**

With a black pen, coloured pencil or crayon, draw small circles on the diagram below where physical pain or discomfort exists in your physical body. Draw any part of your body which is not working optimally.



Please read the Disclaimer:

Information during this coaching program is for educational purposes only. It is not intended to diagnose, prescribe, treat or cure any disease or mental condition. The outcome in this program is the sole responsibility of the client. The FDA has not evaluated this information and I make no curative claims.

□ Check the box if you have read the disclaimer and understand that all outcomes are the sole responsibility of the client.

That’s it! You’re finished - good job!

Now email this questionnaire to me at **healwithmind@gmail.com**