Mel McMahon

FAST LIKE A GIRL CERTIFIED

HEALTH & WELLNESS ASSESSMENT FORM

TWINKLE • TRANSCEND • THRIVE • FLOURISH • FABULOUS • SHINE

Your Details:

Name: | Mobile:

Address: | Date of Birth:

When is best to contact you and how?

Days: M❑ T❑ W❑ T❑ F❑ S❑ S❑ Times: AM ❑ (9am-12noon) PM ❑ (1-5pm) L ❑ 5pm >

Method: Email ❑ Phone ❑ Text/SMS ❑ Zoom/Facetime ❑

Emergency Contact: Name: Mobile:

What are your primary health goals?

Overall, what are your primary reasons for seeking health coaching?

What are some of your primary health concerns?

Please indicate if you struggle with any of these symptoms. (Select as many as required)

Don't worry if there's a symptom not listed, we'll discuss your health concerns in our first consultation.

- ❑ unwanted weight gain
- ❑ digestive discomfort
- ❑ hair loss
- ❑ depressive thoughts
- ❑ constipation
- ❑ headaches
- ❑ irregular menstrual cycles
- ❑ Mood swings / irritability
- ❑ trouble getting to sleep
- ❑ bloating / gas
- ❑ disturbed sleep
- ❑ low motivation
- ❑ diarrhea
- ❑ joint pain
- ❑ low libido
- ❑ anxiety / stress /
- ❑ waking up at night
- ❑ hot flashes / night sweats
- ❑ constant tiredness
- ❑ low bladder control
- ❑ acid reflux
- ❑ muscle cramps / soreness
- ❑ frequent colds/flu
- ❑ feelings of hopeless

Let's talk about your sleep habits:

How do you feel about your sleep?

What time do you normally go to sleep . And wake up:

How often do you wake up at night? Do you often have an afternoon nap?

Do you experience troubles falling to sleep?

Do you keep your mobile phone in your bedroom? Y ❑ N ❑

Do you share a bed with a partner? Y ❑ N ❑

Do you open your window at night? Y ❑ N ❑

Please tell me more about who lives in your home:

How many people live in your home?

Do you have any children whom you look after? If so, what are their names and ages?

Who does most of the grocery shopping? *(check all that apply)*

❑ Me ❑ Spouse/Partner ❑ Roommate(s) ❑ Children ❑ Other Family

Who does most of the cooking? *(check all that apply)*

❑ Me ❑ Spouse/Partner ❑ Roommate(s) ❑ Children ❑ Other Family

Who decides the menu for the week? *(check all that apply)*

❑ Me ❑ Spouse/Partner ❑ Roommate(s) ❑ Children ❑ Other Family

How supported would you say you feel by the people around you?

Little to no support ⟷ very supported

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What are your exercise habits like?

❑ Mainly sedentary ❑ Gentle walk most days ❑ frequent vigorous walk

❑ Gym Class x 3 per week ❑ Gym Class x 4 /w > ❑ Aqua aerobics / Yoga

If you currently don't do any exercise, what would you say is the primary reason?

What work or volunteer activities are you involved in?

Lets talk about the food you normally eat:

Do you have any food sensitivities or allergies?

How frequently would you eat these kinds of foods:

Fresh fruits and Vegetables	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Breads/Pasta/Rice/Grains	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Dairy Products (milk/cheese)	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Meats and animal products	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Processed foods	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Legumes, Seeds, Nuts, oils	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Coffee, Tea, hot drinks	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely
Alcohol (wine or spirits)	❑ Daily	❑ 2-3 x weekly	❑ Weekly	❑ Rarely

Do you smoke?

1-3 smokes / day ❑ 5-10 ❑ a pack/chain ❑ socially ❑ never

Do you take other medicinal substances?

Let's talk about supplements:

Do you regularly take any vitamins, minerals or herbal supplements?

What about any prescribed medication:

Are you on any medication prescribed by a doctor?

How frequently do you take over-the-counter medication?

Can you give me a brief overview of your medical history

Have you ever tried Time Restricted Eating or Intermittent Fasting?

What nutritional, hormonal or toxicity tests have you had?

If so, are you willing to share these tests results with me? Y ❑ N ❑

Trauma or Brain injuries?

Traumatic experiences can impact the body and our health. Do you recall any traumatic experiences in your childhood or throughout your life?

What is your typical stress level on an average day?

❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ High Stress ❑ Very High Stress

How do you normally cope with your stress?

Let's explore your metabolic health ...

Please assign a number to each question using values 1 to 4:

Value	Question:
❑	Do you struggle to lose weight?
❑	Have you been on multiple calorie restriction diets in your life?
❑	Are the weight loss tricks you used to use no longer working?
❑	Have you been gaining weight even though you haven't changed anything with your diet or exercise plans?
❑	Did you gain belly fat when you went into menopause?
❑	Do you get "hangry" if you go without food?
❑	Do you need food when you first get up in the morning?
❑	Do you need to eat every few hours to keep your energy up?
❑	Do you get sleepy after you eat?
❑	Do you get brain fog after you eat?
❑	Do you crave sugar?
❑	Do you crave carbohydrates?
❑	Do you crave alcohol?
❑	Do you forget to eat enough vegetables?
❑	Have you been on more than 5 rounds of antibiotics in your life? (Yes = 4 | 1-5 times = 2 | Never = 1)
❑	Have you been diagnosed with high blood pressure? (Yes = 4 | No = 0)
❑	Are you on a statin for high cholesterol? (Yes = 4 | No = 0)
❑	Are you currently taking one of the weight loss drugs?
❑	Are you over 40 years old (Yes = 4 | No = 0)
❑	Are you post-menopausal (Yes = 4 | No = 0)
❑	If you have a cycle, is it regular (Yes = 0 | Sometimes = 2 | Never = 4)
❑ ❑	If you know these numbers (Yes =) | No = 4) - Is your HgA1c 5 or less - Is your fasting glucose <100 ng/dl?

Mel will discuss your results at your Initial consultation.

Total

Key

<25: Metabolically Healthy

25-30: Moving toward a metabolic crisis

51-96: Metabolically Unhealthy

Let's explore your Toxicity load.

Check all these that are part of your normal routine:

- ❑ Used Contraceptive Pill
- ❑ Use toxic beauty products
- ❑ Used toxic cosmetics
- ❑ Use toxic cleaning products
- ❑ Unwashed Fruit & Vegetables
- ❑ Regularly Microwave food
- ❑ Plastic containers/bottles
- ❑ Use Teflon saucepans
- ❑ Consume cheap meats
- ❑ Eat many processed foods
- ❑ Antibiotic Use
- ❑ Other:

And now for a question you were probably not expecting ...

What is your dream life like?

How often, if any, do you dream? Do you experience any reoccurring dreams? Can you describe any vivid or memorable dreams, even nightmares or night terrors, you have had recently.

How READY do you feel to change your behaviours and habits?

❑ Not at All ❑ Somewhat Ready ❑ Extremely Ready ❑ 100% Ready

What is the greatest obstacle keeping you from changing life habits?

Is your GP aware and supportive of your receiving lifestyle coaching?

❑ Not at All ❑ reluctantly ❑ mildly supportive ❑ very supportive

Are you prepared to invest in these health tools?

Lifesmart® Blood & Ketone Meter

Blood glucose & Ketone Reader.

$20-$50 for metre and testing strips

CareSens Dual ®

Blood Glucose & Ketone Monitor

$30-$40 and testing strips

Continuous Glucose Monitoring

Available through FreeStyle Libre® or Subscription through Vively® Connected to your smartphone.

Blood, D.U.T.C.H., Heavy Metal & Toxic Tests

These tests may be requested depending your unique situation.

Disclaimer: Please acknowledge that it is your responsibility to work directly with your GP or medical practitioner before, during, and after seeking lifestyle medicine coaching. Any information provided is not to be followed without prior approval of your doctor. If you choose to use this information without such approval, you agree to accept full responsibility for your decision. This is vitally important as you incorporate fasting into your lifestyle if you are on insulin and other medications.

Signature: _____ Date: _____