Wholistic Living
Where Joy Comes Naturally

Coaching Intake Form

The questions in this form are designed for you to bring to the surface a description or picture of the current state of your life, your perspective and vision. This is your opportunity to begin designing the way of life that really works for you.

This information is helpful for me to understand who you are, and how I can best coach you in developing realistic goals and support your emotional needs.

1. Contact Data & General:
Your Name: _____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____ Age: _____ Marital Status: _____
Spouse's Name: _____
Children's Names and Ages: _____
_____
Company Name: _____
Title: _____
Business Phone: _____

2. Your Goals:
What are the biggest changes you want to make in your life in the next 3 months?
1. _____
2. _____
3. _____
What are the biggest changes you want to make in your life over the next 3 years?
1. _____
2. _____
3. _____
What, if any, are the barriers which prevent you from achieving these things?

What would you say have been your 3 greatest accomplishments to date?
1. _____
2. _____
3. _____

EXPECTATIONS:
What do you expect to achieve in life as a result of hiring me as your life coach?

3. Your History:
What is the hardest thing in your life that you have had to overcome? How did you do it?

What major transitions have you had in the past two years? (Example: Entering or approaching a different age, a new or different relationship, job role, a move, a change in children's ages/stages, etc.)

Who are or have been your major role models? Why?

Have you worked with a coach before or a similar one-on-one adult relationship (e.g. Soccer coach, piano teacher, and therapist)?
If so, what worked well for you and what did not work in the relationship(s)?

Your Life Story / History: What would you like to share with me?

4. Improvements:
Please list any improvements you would like to make in the following areas:
Family:

Health/Self Care:

Career/Business life:

Relationships (intimate and friendships):

Living Space/Home:

Service/Personal Growth/Learning:

Creativity:

Play / Leisure time:

Other areas:

5. Your Life:
Who are the key people in your life and what do they provide for you?

What is your favorite part of your typical day? Why?

What is your least favorite part of your typical day? Why?

Looking at the past six months of your life, do you like the direction your life is moving in? Explain.

Do you feel your life is one of your choosing? If not, which parts are being chosen for you? What is a dream or goal you have given up on?

What do you think is NOT possible to achieve in your lifetime that you wish you could?

What part of yourself, if any, have you given up on?

On a scale of 1 to 10 with 10 high, rate the quality of your life today.

6. Health and Social History:

How tall are you? _____ How much do you weigh? _____
What size clothes do you wear? Shirts: _____ Pants: _____
In the greatest detail possibly please describe what you eat and drink for:
Breakfast:

Lunch:

Dinner:

Snacks and any other time:

What do you feel is your biggest weakness with food? (dessert, soda, candy, French fries)

Who is your primary physician? When was your last Physical?

Do you drink alcohol? _____ How much? _____ How Often? _____
Do you smoke cigarettes? _____ How much? _____ How Often? _____
Do you consume caffeine? _____ How much? _____ In what form? _____
Have you been diagnosed with any chronic health conditions (heart disease, high blood pressure, high cholesterol, autoimmune disorders, asthma, allergies, etc)?

Please list any and all medications that you take on a regular basis including supplements:

Name of Medicine	Dose of Medicine	What is it for?	Who Prescribed it?

Do you exercise? _____ How often? _____ For how long? _____
What type of exercise do you do? _____
Do you enjoy other types of physical activity? (Such as hiking, gardening, yard work, organized sports, etc.) _____
Do you belong to a gym? Or have exercise equipment in your home? _____
What barriers do you have to exercise?

Do you use electronic devices? Which ones? (Cell phone, texting, Face Book, gaming, etc)

Do you ever feel that your use of these things is causing a problem in your life?

7. Tolerations:
List five things that you're personally tolerating or putting up with in your life at present. (Examples: clutter, rude friends, tight shoes, dented car, job dissatisfaction, dead plants, broken equipment, cranky people in your life, kid stressors, overscheduled, etc.)
1. _____
2. _____
3. _____
4. _____
5. _____

In a typical week, what do you spend a great amount of time doing?

What are your primary stressors? (What stresses you out?)

On a scale of 1 to 10, 10 high, rate the amount of stress in your life right now.

8. Potential and Possibility:
If you could develop a personal or professional vision for yourself what would it be?

What would you like to give others (friendship, love, kindness, service, support, money, etc)?

What would be your personal or professional legacy, which you would give to others, when the day's and seasons are over, when it's all been said and done?

What do you know for sure?

9. Other Background:
Hobbies:

What do you spend most of your leisure time doing?

Who do you spend most of your leisure time with?

Candida Questionnaire and Score Sheet

Candida albicans can affect the digestive tract and the body as a whole. Although it is normal to have a certain level of Candida present in the body, certain factors can lead to a Candida overgrowth that can contribute to a wide variety of symptoms and conditions. This Questionnaire is a tool to evaluate the likelihood of whether Candida may be playing a role in your health. With a positive result from the questionnaire, more specific testing is used verify the presence or absence of Candida in your body. Questions in Section A focus on your medical history—factors that promote the growth of *Candida albicans* and that frequently are found in people with yeast-related health problems.

In Section B you'll find a list of 23 symptoms that are often present in patients with yeast-related health problems. Section C consists of 33 other symptoms that are sometimes seen in people with yeast-related problems—yet they also may be found in people with other disorders. Filling out and scoring this questionnaire should help you evaluate the possible role *Candida albicans* contributes to your health problems. Yet, it will not provide an automatic ‘‘yes’’ or ‘‘no’’answer.

Section A: History

Circle the points for each question if it is a “yes” answer.

	Point Score
1. Have you taken tetracyclines or other antibiotics for acne for 1 month (or longer)?	35
2. Have you at any time in your life taken broadspectrum antibiotics or other antibacterial medication for respiratory, urinary or other infections for two months or longer, or in shorter courses four or more times in a one-year period?	35
3. Have you taken a broad-spectrum antibiotic drug—even in a single dose?	6
4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25
5. Are you bothered by memory or concentration problems—do you sometimes feel spaced out?	20
6. Do you feel ‘‘sick all over’’ yet, in spite of visits to many different physicians, the causes haven't been found?	20
7. Have you been pregnant...	
Two or more times?	5
One time?	3

8. Have you taken birth control pills...
For more than two years? 15
For six months to two years? 8

9. Have you taken steroids orally, by injection or inhalation?
For more than two weeks? 15
For two weeks or less? 6

10. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke . . .
Moderate to severe symptoms? 20
Mild symptoms? 5

11. Does tobacco smoke really bother you? 10

12. Are your symptoms worse on damp, muggy days or in moldy places? 20

13. Have you had athlete's foot, ring worm, ''jock itch'' or other chronic fungous infections of the skin or nails?
Have such infections been...
Severe or persistent? 20
Mild to moderate? 10

14. Do you crave sugar? 10

TOTAL SCORE, Section A

Section B: Major Symptoms

For each of your symptoms, enter the appropriate figure in the Point Score column:
If a symptom is **occasional or mild** ..... 3 points
If a symptom is **frequent and/or moderately severe** ..... 6 points
If a symptom is **severe and/or disabling** ..... 9 points
Add total score and record it at the end of this section.

Point Score

1. Fatigue or lethargy

2. Feeling of being ''drained''

3. Depression or manic depression

4. Numbness, burning or tingling

_____

5. Headache

_____

6. Muscle aches

_____

7. Muscle weakness or paralysis

_____

8. Pain and/or swelling in joints

_____

9. Abdominal pain

_____

10. Constipation and/or diarrhea

_____

11. Bloating, belching or intestinal gas

_____

12. Troublesome vaginal burning, itching or discharge

_____

13. Prostatitis

_____

14. Impotence

_____

15. Loss of sexual desire or feeling

_____

16. Endometriosis or infertility

_____

17. Cramps and/or other menstrual irregularities

_____

18. Premenstrual tension

_____

19. Attacks of anxiety or crying

_____

20. Cold hands or feet, low body temperature

_____

21. Hypothyroidism

_____

22. Shaking or irritable when hungry

_____

23. Cystitis or interstitial cystitis

_____

TOTAL SCORE, Section B

_____

Section C: Other Symptoms

For each of your symptoms, enter the appropriate figure in the Point Score column:

If a symptom is **occasional or mild** ..... 1 point
If a symptom is **frequent and/or moderately severe** ..... 2 points
If a symptom is **severe and/or disabling** ..... 3 points
Add total score and record it at the end of this section.

Point Score

1. Drowsiness, including inappropriate drowsiness

_____

2. Irritability

_____

3. Incoordination

_____

4. Frequent mood swings

_____

5. Insomnia

_____

6. Dizziness/loss of balance

_____

7. Pressure above ears . . . feeling of head swelling

_____

8. Sinus problems . . . tenderness of cheekbones or forehead

_____

9. Tendency to bruise easily

_____

10. Eczema, itching eyes

_____

11. Psoriasis

_____

12. Chronic hives (urticaria)

_____

13. Indigestion or heartburn

_____

14. Sensitivity to milk, wheat, corn or other common foods

_____

15. Mucus in stools

_____

16. Rectal itching

_____

17. Dry mouth or throat

_____

18. Mouth rashes, including ‘‘white’’ tongue

_____

19. Bad breath

_____

20. Foot, hair or body odor not relieved by washing

_____

21. Nasal congestion or postnasal drip

_____

22. Nasal itching

_____

23. Sore throat

_____

24. Laryngitis, loss of voice

_____

25. Cough or recurrent bronchitis

_____

26. Pain or tightness in chest

_____

27. Wheezing or shortness of breath

_____

28. Urinary frequency or urgency

_____

29. Burning on urination

_____

30. Spots in front of eyes or erratic vision

_____

31. Burning or tearing eyes

_____

32. Recurrent infections or fluid in ears

_____

33. Ear pain or deafness

_____

TOTAL SCORE, Section C

_____

Total Score, Section A

_____

Total Score, Section B

_____

GRAND TOTAL SCORE

_____

The Grand Total Score will help you and your physician decide if your health problems are yeast-connected. Scores in women will run higher, as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.