Lifestyle & Health History

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Please complete this form before your first Compass session. Everything you share is confidential and kept in your Coach's private office. Skip anything you'd rather talk through in person.

1. About You

Full name _____

Today's date _____

Date of birth _____

Phone _____

Email _____

Home address _____

Preferred contact method ☐ Phone ☐ Text ☐ Email

Emergency contact (name, relationship, phone) _____

Primary physician (name, phone) _____

Inner Circle member? ☐ Yes ☐ No

How did you hear about Inner Light? _____

2. Readiness for Movement

Compass sessions may include light movement and breathwork. If you answer **Yes** to any question below, please bring written clearance from your physician to your first session.

Question	Yes	No
Has a doctor ever said you have a heart condition or high blood pressure?	☐	☐
Do you feel chest pain at rest, during daily activities or during exercise?	☐	☐
In the past 12 months, have you lost your balance from dizziness or lost consciousness?	☐	☐
Have you been diagnosed with another chronic medical condition?	☐	☐
Do you take prescription medication for a chronic condition?	☐	☐
Do you have a bone, joint or soft-tissue problem that could get worse with activity?	☐	☐

Question	Yes	No
Has a doctor ever said you should only exercise under medical supervision?	☐	☐
Are you currently pregnant or less than 12 months postpartum?	☐	☐

3. Medical Information

How would you describe your health right now?

☐ Thriving ☐ Healthy ☐ Not feeling my best ☐ Unwell ☐ Other: _____

Current medications (prescription and over-the-counter)

Medication	Dose	How often	Taken as prescribed?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If any medication isn't taken as prescribed, what gets in the way?

Vitamins, minerals, herbs or supplements

Supplement	Amount per day

Date of your last physician visit

Recent lab work (if known)

Test	Date	Result
Total cholesterol		
HDL		
LDL		
Triglycerides		
Blood sugar (fasting glucose or A1C)		

Health history checklist (check any that apply now or in the past)

- ☐ Allergies: _____
- ☐ Amenorrhea (missed periods)
- ☐ Anemia
- ☐ Anxiety or panic attacks
- ☐ Arthritis
- ☐ Asthma
- ☐ Back, neck or joint pain
- ☐ Celiac disease
- ☐ Chronic pain
- ☐ Chronic sinus condition
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Disordered eating
- ☐ GERD (acid reflux)
- ☐ High blood pressure
- ☐ Hypermobility (incl. hEDS)
- ☐ Hypoglycemia
- ☐ Hypo- or hyperthyroidism
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Irritability
- ☐ Irritable bowel syndrome (IBS)
- ☐ Peri- or menopausal symptoms
- ☐ Migraines
- ☐ Osteoporosis
- ☐ PMS
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Pregnancy
- ☐ Skin conditions
- ☐ Sleep apnea
- ☐ Ulcer

Major surgeries (with year)

Past injuries

Other health conditions not listed

4. Family History

Has a parent, sibling or grandparent been diagnosed with any of the following?

Condition	Relation	Age at diagnosis
Heart disease		
High cholesterol		
High blood pressure		
Cancer (type: _____)		
Diabetes		
Osteoporosis		

5. Nourishment

What would you like to change about the way you eat?

Diets you have followed, past or present

Type of diet	Reason	Prescribed by a physician?	How long
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Have you worked with a registered dietitian or diabetes educator?

☐ Yes ☐ No

Would you like a referral?

☐ Yes ☐ No

Your biggest nutrition challenges (for example, late-night eating, skipping meals, eating on the go)

Water per day (8 oz glasses)

Other beverages and amount per day (coffee, tea, soda, juice, energy drinks)

Food allergies or intolerances

Who shops and cooks in your home?

☐ Me ☐ Partner or spouse ☐ Parent ☐ Shared ☐ Minimal cooking

Meals eaten out per week

Where you usually eat out (fast food, fast casual, sit-down, takeout)

Meal	Usual spot or type
Breakfast	
Lunch	
Dinner	
Snacks	

Foods you crave, and when

6. Daily Habits

Habit	Do you use it?	How much or how often
Alcohol	☐ Yes ☐ No	____ days per week, ____ drinks on average
Caffeine	☐ Yes ☐ No	____ cups or servings per day
Tobacco or nicotine (cigarettes, cigars, chew, vape)	☐ Yes ☐ No	____ per day

7. Movement

Your current weekly routine

Type	Per week
Cardio	____ minutes
Strength training	____ sessions
Flexibility, mobility or yoga	____ sessions
Sports or recreation	____ minutes

Activities you do now

Other regular movement (walking the dog, gardening, taking the stairs)

Injuries that limit your movement

Any activity restrictions from a doctor or therapist

How do you feel about exercise right now?

Movement you love, or would love to try

8. Work and Daily Rhythm

Employment status

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Student ☐ Caregiver ☐ Other

Occupation

Typical work schedule

How active are you during your workday?

☐ Mostly sitting ☐ Some standing and walking ☐ On my feet most of the day ☐ Physically demanding

9. Sleep, Stress and Nervous System

Average hours of sleep per night

Sleep quality (1 = restless, 10 = deeply restorative)

Energy level most days (1 = depleted, 10 = vibrant)

Stress level most days (1 = calm, 10 = overwhelmed)

Your biggest source of stress right now

When you're stressed, your appetite

☐ Increases ☐ Stays the same ☐ Decreases

What helps you unwind? (breathwork, meditation, time outdoors, music, movement, other)

10. Body Trends (Optional)

At Inner Light, numbers are *trendline data*, not judgment. Answer only what feels useful, or leave this section for an in-person conversation.

Your weight goal

☐ Lose ☐ Gain ☐ Maintain ☐ Not a focus for me

Measure	Your answer	Don't know	Prefer not to say
Current weight		☐	☐
Lowest weight in the past 5 years		☐	☐
Highest weight in the past 5 years		☐	☐
Weight where you feel your best		☐	☐
Waist circumference		☐	☐
Hip circumference		☐	☐
Body fat %		☐	☐

11. Your Compass

How ready do you feel to make a change? (1 = just exploring, 10 = ready now)

Your top three goals, in order of importance

1.

2.

3.

Is weight change one of your goals?

☐ Yes ☐ No If yes, tell us more:

What's drawing you to make a change now?

Three months from now, what would tell you this was worth it?

12. Acknowledgment

By signing below, I confirm that:

- The information on this form is accurate and complete to the best of my knowledge.
- I will tell my Coach about any change in my health, medications or injuries.
- I understand that Compass Coaching is not medical care, therapy or counseling, and does not replace advice from my physician or other licensed providers.
- I understand this form is kept confidential, as described in my Compass Coaching Agreement.

Client signature _____

Printed name _____

Date _____