YMCA OF THE NORTH

Health Coaching
First Session Questionnaire

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Please take time to answer this questionnaire and submit to your Health and Wellbeing Coach at least 24 hours before your appointment. Thank you.

Name

Date of Birth

Please select all that apply:
☐ I am 18 years of age or older.

GENERAL HEALTH AND WELLBEING

Describe your current health and wellbeing goal(s) and/or concerns:

List any providers currently supporting your health and wellbeing (e.g., doctors, nutritionists, physical therapists, personal trainers, movement specialists, therapists, coaches, acupuncturists, homeopaths, naturopaths, or other healing specialists):

Are you currently taking any medications and/or supplements? If yes, please specify:

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CONNECT

Describe your support network (e.g., friends, family, pets, partners, co-workers):

Do you have a health and wellbeing accountability partner(s)? If yes, please explain:

Please rate your level of satisfaction (1) being lowest, (5) being highest:

Regarding how your relationships among family members impact your health/wellbeing	1 2 3 4 5
Regarding how your relationships among friends impact your health/wellbeing	1 2 3 4 5
Regarding your how your relationships with work/co-workers impact your health/wellbeing	1 2 3 4 5

Do you have any hobbies and/or volunteer? If yes, please describe:

NOURISH

Rate the quality of your food choices? Low 1 2 3 4 5 6 7 8 9 10 High

Are you currently following or have you ever followed a special food plan for health reasons or otherwise? ☐ Yes ☐ No

If yes, please describe plan:

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MOVE

Do you engage in movement practices/exercise? ☐ Yes ☐ No

If yes, please describe the movement practices/exercise:

If yes, how many times (on average) per week? Low 1 2 3 4 5 6 7 8 9 10 High

REFLECT

Do you have a reflective practice(s) (e.g., prayer, meditation, journaling, nature walks)? If yes, please explain:

What is your satisfaction level with your current reflective practice(s)? Low 1 2 3 4 5 6 7 8 9 10 High

How would you rate your ability to focus? Low 1 2 3 4 5 6 7 8 9 10 High

RESTORE

How many hours of sleep do you average per night? Low 1 2 3 4 5 6 7 8 9 10 High

Please rate your quality of sleep Low 1 2 3 4 5 6 7 8 9 10 High

Please rate your typical energy level Low 1 2 3 4 5 6 7 8 9 10 High

Please rate your typical mood Low 1 2 3 4 5 6 7 8 9 10 High

Please describe your typical mood (e.g., positive, driven, anxious, angry, sad):

Please rate the level of chronic stress in your life Low 1 2 3 4 5 6 7 8 9 10 High

Please describe any current sources of chronic stress, including ongoing stressors and recent stressors in your life:

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RESTORE

Please describe past stressful life experiences, events or conditions (e.g., history with physical conditions, addiction, or mental/emotional health concerns):

What are your practices/activities for managing stress?

COMMITMENT

Please describe what changes you would make in your life if there were no limitations:

Describe your beliefs regarding your own ability to transform your health and overall wellbeing:

What strengths do you bring to the coaching process?

How ready, willing and able are you to make changes in your life?

- ☐ Not motivated to change
- ☐ Considering changes
- ☐ Preparing to make changes
- ☐ Actively making changes
- ☐ Maintaining changes made

Is there any other information you would like to share with your provider?

Client Name

Parent or Guardian (if applicable)

Signature

Date