NAME

EMAIL ADDRESS

PHONE

DOB

Assessment Form

Please note that this form needs to be completed and returned (at minimum) 2 days prior to your first appointment.
Capital Cardiology Associates, Attn: Benita Zahn, 7 Southwoods Blvd., Albany, NY 12211
This form can also be returned via email to: benitahealthcoach@gmail.com

Rate the importance of these areas of wellbeing on a scale from 1-10:
Not at all - Equal to what I want to achieve now - Most important thing in my life now
1 —— 2 —— 3 —— 4 —— 5 —— 6 —— 7 —— 8 —— 9 —— 10

Life Satisfaction ______
Energy ______
Exercise ______
Nutrition ______
Weight ______
Mental and Emotional Fitness ______
Health ______

Readiness to make a change
A -I have no interest to make a change at this time
B-I am thinking about making a change
C-I am planning to make a change in 6 months
D-I am planning to make a change this month
E-I am ready to make a change this month

Life Satisfaction ______
Energy ______
Mental & Emotional Fitness ______
Exercise ______
Nutrition ______
Weight ______
Health ______

PRIORITIES for working with a health/wellness coach are (X all that apply):

- ☐ Improve well-being (health and happiness)
- ☐ Improve energy
- ☐ Increase physical activity
- ☐ Lose weight
- ☐ Improve eating habits
- ☐ Improve work/life balance

SLEEP: I sleep: (X one)
- ☐ Less than 6 hours
- ☐ More than 6 Hours
- ☐ Trouble sleeping through the night
- ☐ Trouble falling asleep

STRESS: To what extent does stress impact your life? (X one)
- ☐ Quite a bit
- ☐ Not at all
- ☐ Occasionally

Emotions: (X all that apply)
- ☐ I feel calm/peaceful
- ☐ I am a happy person
- ☐ I carve out ME time
- ☐ I had FUN today
- ☐ I FELT downhearted/blue
- ☐ I have FELT unworthy / unimportant
- ☐ My interest in activities has changed

EXERCISE
Any physical limitations Circle one: ☐ YES ☐ NO
Do you exercise regularly Circle one: ☐ YES ☐ NO
How many days a week do you engage in aerobic activity ______
How many days a week do you engage in strength training ______
How many days a week do you engage in flexibility exercise ______

NUTRITION
Do you eat breakfast: YES ☐ NO ☐
Do you snack: ☐ YES ☐ NO
How many times a day do you snack ______
How many times a day is your snack food 'junk' food ______

How many cups (8oz) of water do you drink, daily ______
How many alcoholic drinks do you consume daily (liquor, wine, beer) ______
How many soft drinks do you consume daily (8oz) ______
What type of and how many servings of bread / grains daily (list please) ______

How many servings of fruit and vegetables/daily ______
Do you drink ☐ coffee ☐ tea
How much ______

DO YOU SMOKE? – cigarettes or other tobacco products? ☐ YES ☐ NO
If so, how many / how often ______

What, if any, health diagnosis are you being treated for? ______