UVA-WorkMed

Chronic Care Coaching
Client Intake

Name____ Date_________ DOB _________

Mailing address: ____
Email address: ___________________________ UVA Dept. or Employer: ___________________________
Phone #: ___________________________ Insurance Carrier: ___________________________

BP: _________ Height: _______ Weight: ________ Waist Circumference: __________

Describe how you are personally and professionally supported at home and work?

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____

Describe how you think and feel about change.

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____

List your known health risks and/or medical issues, as well as current medications.

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____
____

List any known injuries or physical limitations that might prevent you from exercising:

____
____
____

List any known family medical issues from (parents, grandparents, siblings**):**

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____

What are your health and wellness priorities and goals?

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____

Are you aware of any obstacles that might interfere with your goals? If so, can you list them:

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Do you smoke currently? ___________ If yes, number of cigarettes, cigars, or pipes per day: __________

Please feel free to make any other notes and/or comments.

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Client Signature__________________________________ Date______________________

UVA-WorkMed
1910 Arlington Blvd.
P.O. Box 800357
Charlottesville, VA 22908-0357
Phone: 434-243-0075
Fax: 434-243-0078
www.uvaworkmed.com