

# Marin Health Coach

Holistic Strength + Vitality for Women 40+

Welcome to the Amie Method™. Let's jump right in. Please complete the personal review form here and we can then schedule the process when we meet in person.

## AMIE Method – Personal Review Form

Fuel. Strengthen. Thrive.

### Basic Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Communication Method: \_\_\_\_\_

### Current Life Snapshot

What brings you to the AMIE Method? What are you hoping to gain from this experience?

\_\_\_\_\_

Top 3 Goals (Physical, Emotional, Lifestyle):

\_\_\_\_\_

What challenges have made progress difficult in the past?

Time     Motivation     Emotional Eating     Hormones

Injury/Pain     Other: \_\_\_\_\_

### Midlife Wellness & Hormonal Health

Current Stage:

Perimenopause     Menopause     Postmenopause     Not Sure     N/A

Recent Symptoms (Check all that apply):

Fatigue     Weight Gain     Mood Swings     Poor Sleep

Brain Fog     Irregular Periods     Hot Flashes     Low Libido

Joint Pain     Headaches     Migraines     Other: \_\_\_\_\_

Do you take HRT (Hormone Replacement Therapy)?

Yes     No     Considering it

If yes, please list type and dosage (if known): \_\_\_\_\_

Have you had recent hormone or thyroid testing?

Yes     No

Findings (if any): \_\_\_\_\_

## Nutrition & Relationship with Food

Current Eating Habits:

Structured     All or Nothing     Emotional Eating     Grazing

Restrictive     Confused

What does a typical day of eating look like for you?

---

---

Any dietary restrictions or preferences?

---

Do you often feel:

Full     Hungry     Cravings     Afraid of Foods

What is your relationship with food?

---

What is your relationship with your body?

---

What brings you joy?

---

---

---

# Marin Health Coach

Holistic Strength + Vitality for Women 40+

## Medications, Supplements & Family History

Are you currently taking any medications? Please list:

---

Do you take any supplements or vitamins? Please list:

---

Any family history of illnesses or chronic conditions?

---

---

## Movement & Physical Health

Current exercise routine (type and frequency):

---

---

Any injuries or physical limitations?

---

---

Movement priorities (check all that apply):

Building Strength     Improving Balance/Core     Gaining Energy

Losing Fat     Flexibility     Consistency

## Mindset, Lifestyle & Stress

Current stress level (1 to 10): \_\_\_\_\_

Top sources of stress:

---

Sleep Quality:

Restful     Trouble Falling Asleep     Wake Often     Wake Tired

# Marin Health Coach

Holistic Strength + Vitality for Women 40+

Do you feel supported?

Yes     Somewhat     No

---

## Body Image & History

What was your relationship with your body growing up?

---

What is your relationship with your body now?

---

## Vision for Thriving

What does thriving look like for you in this chapter of life?

---

What do you want to feel more of (check all that apply):

Energy     Peace     Strength     Control

Confidence     Joy     Connection

Is there anything else you'd like to share?

---

---

---

---

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you so much for sharing this with me and letting me be part of this next chapter in your life.