Women's Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name:_____Last Name_____Age:_____

Home Phone:_____Mobile Phone:_____

Email:_____

Birthdate:_____Place of Birth:_____

Height:_____ Current Weight:_____ Weight 6 months ago:_____ One year ago:_____

Would you like your weight to be different? _____ If so, what?_____

SOCIAL INFORMATION

Relationship status:_____

Where do you currently live?_____

Children: _____

Pets:_____

Occupation:_____

How many hours per week do you work?_____

HEALTH INFORMATION

Please list your main health concerns:_____
_____
_____
_____
_____
_____

At what point in your life did you feel best?

_____
_____

Any serious illnesses/hospitalizations/injuries?

_____
_____
_____

How is/was the health of your mother?

_____

How is/was the health of your father?

_____

What is your ancestry?_____

How is your sleep?_____How many hours?_____

Do you wake up at night? If so, why do you think and what time?

_____
_____

Any pain, stiffness, or swelling?_____

Constipation/Diarrhea/Gas?_____

Allergies or sensitivities?

_____
_____

WOMEN'S HEALTH

Are your periods regular?_____How many days is your flow?_____

Painful or symptomatic?_____

Explain:_____
_____
_____

Reached or approaching menopause?_____
Explain:_____
_____

Birth control
history:_____

Do you experience yeast infections or urinary tract infections?_____
Explain:_____

MEDICAL INFORMATION

What is your blood type?_____

Please list any supplements or medications you are currently taking:_____
_____
_____
_____

Any healers, helpers, or therapies with which you are involved? Please list:_____
_____

What role do sports and exercise play in your life?
_____
_____

Anything else you would like to share about your medical history?
_____
_____
_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

Do you cook?

What percentage of your food is home-cooked?

Where do you get the rest from?

What percentage of your meals are from a restaurant? From where?

Do you crave sugar, coffee, cigarettes, alcohol, or have any major addictions?

What role does or has religion/spirituality played in your life?

The most important thing I should do to improve my health is:

Anything else you would like to share?