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: ____________________

Email: ____________________ What is the best way to reach you? ____________________

Phone: Home: ____________ Work: ____________ Mobile: ____________

Age: ________ Height: ________ Birth date: ____________ Place of Birth: ____________

Current weight: ____________ Six 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: ____________ Occupation: ____________

Do you enjoy any hobbies? ____________________

HEALTH INFORMATION

What are your main health concerns? ____________________

What are your goals? ____________________

At what point in your life did you feel best? ____________________

Have there been any serious illnesses, hospitalizations or injuries? ____________________

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Women's Health History

HEALTH INFORMATION (continued)

How is/was the health of your mother? ______________________

How is/was the health of your father? ______________________

What is your ancestry? ______________________ What blood type are you? ________

How is your sleep? __________ How many hours? __________ Do you wake up at night? __________

If yes, why? ______________________

Any pain, stiffness, or swelling? ______________________

Constipation/Diarrhea/Gas? ______________________

Allergies or sensitivities? ______________________

WOMEN'S HEALTH

Do you still have periods? ________ How many days is your flow? _____ How frequent? __________

Are they painful or symptomatic? ______________________

Are you pre or post menopausal? ______________________

Do you experience any symptoms? ______________________

____

Do you use any hormone therapy? ______________________

____

MEDICAL INFORMATION

Please list any supplements or medications: ______________________

____

Do you engage in any other healing modalities or therapies? ______________________

____

Are you physically active? Please describe: ______________________

____

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Women's Health History

FOOD INFORMATION

What were your typical meals like as a child? Did you eat family meals together? ______________

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food lifestyle like currently?

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? ______________________________

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

____

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

____

ADDITIONAL COMMENTS

Anything else you would like to share? ______________________________

____

____

____

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