



WOMEN'S HEALTH HISTORY

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

PERSONAL

First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Email: _____ How often do you check your email? _____

Home Phone: _____ Mobile Phone: _____

Height: _____ Waist Circumference: _____ (measurement taken level with your belly button)

Current Weight: _____ Weight One Year Ago: _____ Would you like your weight to be different? _____

If so, how? _____

SOCIAL

Relationship Status: _____

Where do you live? _____

Any children? _____ Any pets? _____

Occupation: _____ How many hours do you work per week? _____

Are you part of a community (social/religious)? _____ Are you happy? _____

On a scale of 1-10, how would you rate your stress level? _____

MEDICAL/GENETICS

List all supplements or medications: _____

Are you involved with any healers, helpers, or therapies? _____

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

How is/was your mother's health? _____

How is/was your father's health? _____

Have you ever done genetic testing? _____ If so, were there any noted concerns? _____

Were you adopted? _____ What is your ancestry? _____ What is your blood type? _____

GENERAL HEALTH

What are your main health concerns? _____

Any other concerns and/or goals? _____

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

Any current or previous serious illnesses, hospitalizations, or injuries? _____

How is your sleep? _____ How many hours do you sleep per night? _____

Do you wake up during the night? If so, why? _____

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Are your periods painful or symptomatic? If so, please explain: _____

Have you reached or are you approaching menopause? If so, please explain: _____

Are you sexually active? _____ Do you have any sex related health concerns? _____

What is your birth control history? _____

Do you experience yeast infections or urinary tract infections? If so, please explain: _____

FOOD

Will your family and 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 does your non-home-cooked food come from? _____

Have your eating habits changed significantly from when you were a child? _____ If so, how? _____

What foods do you typically eat these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

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

What is the most important thing you should change about your diet to improve your health?

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____
