FEMALE TEEN HEALTH HISTORY

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

PERSONAL

First Name: ____

Last Name: ____

Age: ________ Height: ____________ Date of Birth: ____________ Place of Birth: ____________________

Email: ________________________ How often do you check your email? ____________________

Home Phone: ______________ Work Phone: ____________ Mobile Phone: ____________________

Current Weight: ____________ Weight Six Months Ago: ___________ Weight One Year Ago: ______________

Would you like your weight to be different? __________ If so, how?______________________________

Why did you sign up for a Health History? ______________________________________

SOCIAL

What is your relationship status? ____

Do you have any pets? ________________________________ What grade are you in? ___________

Do you enjoy school? Please explain: ______________________________________

____

Do you have a large or small group of friends? _________________________________

GENERAL HEALTH

What are your main health concerns? ____

____

____

Any other concerns? ____

____

____

Any serious illnesses, hospitalizations, or injuries? _____________________________

____

How is/was your mother’s health? ____

How is/was your father’s health? ____

© 2009, 2017 Integrative Nutrition, Inc. | Reprinted with permission

GENERAL HEALTH (continued)

What is your ancestry? ______________________________

How is your sleep? ______________________ How many hours do you sleep per night? __________

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

Any constipation, diarrhea, or gas? ______________________________

Any allergies or sensitivities? ______________________________

FEMALE TEEN HEALTH

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

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

What is your birth control history? ______________________________

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

____

MEDICAL

Are you concerned with body image? If so, please explain: ______________________________

____

Do you take any supplements or medications? ______________________________

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

____

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

____

FOOD

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

What percentage of your food is home-cooked? _______ Do you enjoy the food? ____________

Where does your non-home-cooked food come from? ______________________________

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

____

© 2009, 2017 Integrative Nutrition, Inc. | Reprinted with permission

FEMALE TEEN HEALTH HISTORY

FOOD (continued)

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

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? ____

____

____

© 2009, 2017 Integrative Nutrition, Inc. | Reprinted with permission