



Womens

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: _____ Cell: _____

Current Weight: _____ Weight 6 Months Ago: _____ Weight One Year

Ago: _____

Would you like your weight to be different? Y N If so, how? _____

Have you or do you have issues with your weight? Y N Please explain: _____

Social

Relationship Status: _____

Where do you live? _____

Any Children? _____ Pets? _____

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

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? _____



Womens

General Health (Continued)

How is/was your mother's health? _____

How is/was your father's health? _____

What is your ancestry? _____ Blood Type? _____

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

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

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

Women's Health

Are your periods regular? Y N How many days is your flow? _____

How frequent? _____

Painful or symptomatic? Please explain: _____

Birth control history: _____

Do you experience yeast infections or UTIs? Please explain: _____

Medical

List all supplements or medications: _____

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

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



Womens

Food

Will your family and friends be supportive of you making food and/or lifestyle changes? Y N

Do you cook? Y N What percentage of your food is home-cooked? _____

Where does the non-home-cooked food come from? _____

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? _____

What foods do you often eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Additional Comments

Is there anything else you would like to share? _____

