## WOMEN'S HEALTH HISTORY

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

PERSON	AL						
First Name	):						
Last Name	:						
Age:	Height:	Date of Birth:	Place of Birth:				
Email:		Hov	v often do you check your email?				
Home Pho	ne:	Work Phone:	Mobile Phone:				
Current We	eight:	Weight Six Months Ago:	Weight One Year Ago:				
Would you	like your weight to	be different? If so, how?_					
SOCIAL							
Relationsh	ip Status:						
Where do	you live?						
Any childre	en?		Any pets?				
Occupation	າ:	How	How many hours do you work per week?				
GENERA	L HEALTH						
What are y	our main health co	ncerns?					
Any other o	concerns and/or go	als?					
At what po	int in your life did yo	ou feel your best?					
Any curren	t or previous seriou	s illnesses, hospitalizations, or injuries?					
How is/was	s your mother's hea	lth?					
		h?					
	ur ancestry?		What is your blood type?				

## WOMEN'S HEALTH HISTORY

GENERAL HEAL	TH (continued)								
How is your sleep?	low is your sleep? How many hours do you sleep per night?								
Do you wake up du	ring the night? If so	, why?							
Any pain, stiffness,	or swelling?								
Any constipation, d	iarrhea, or gas?								
Any allergies or ser	nsitivities?								
WOMEN'S HEAL	лн								
Are your periods re	gular? How	many days is your flow?	How f	requent?					
Are your periods painful or symptomatic? If so, please explain:									
Have you reached	or are you approach	ning menopause? If so, pleas	e explain:						
What is your birth o	control history?								
Do you experience	yeast infections or	urinary tract infections? If so,	please explain:						
MEDICAL									
List all supplements	s or medications:								
Are you involved w	ith any healers, help	pers, or therapies?							
What role do sports	s and exercise play	in your life?							
FOOD									
Will your family and	d friends be support	ive of your desire to make foo	d and/or lifestyle cha	anges?					
Do you cook?		What percentage of your fo	ood is home-cooked	?					
Where does your n	on-home-cooked fo	od come from?							
What foods did you	ı eat often as a child	1?							
<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>					

## WOMEN'S HEALTH HISTORY

FOOD (continue	ed)				
What foods do y	ou typically eat these d	ays?			
<u>Breakfast</u>	Lunch	<u>Dinner</u>	Snacks	<u>Liquids</u>	
		_	_	<u>-</u>	
		_	_	_	
Do you crave su	gar, coffee, or cigarette	s? Do you have any othe	er major addictions?	_	
What is the mos	t important thing you sh	ould change about your	diet to improve your hea	lth?	
ADDITIONAL	COMMENTS				
		share?			
-	-				