



## Female Teen 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: \_\_\_\_\_ How often do you check email? \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Current weight: \_\_\_\_\_ Weight six months ago: \_\_\_\_\_ One year ago: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

Why did you come for a Health History? \_\_\_\_\_

### SOCIAL INFORMATION

What is your relationship status? \_\_\_\_\_

What grade are you in? \_\_\_\_\_ Do you enjoy school? Please explain: \_\_\_\_\_

Do you have a large or small group of friends? \_\_\_\_\_

### HEALTH INFORMATION

Please list your main health concerns: \_\_\_\_\_

Other concerns? \_\_\_\_\_

Any serious illnesses/hospitalizations/injuries? \_\_\_\_\_

How is/was the health of your mother? \_\_\_\_\_

How is/was the health of your father? \_\_\_\_\_

Where do your parents and grandparents come from? \_\_\_\_\_



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### HEALTH INFORMATION (continued)

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

Why? \_\_\_\_\_

Constipation/Diarrhea/Gas? \_\_\_\_\_

Allergies or sensitivities? Please explain: \_\_\_\_\_

### FEMALE TEEN HEALTH

Are your periods regular? \_\_\_\_\_ How many days is your flow? Painful How frequent? \_\_\_\_\_

or symptomatic? Please explain: \_\_\_\_\_

What is your birth control history? \_\_\_\_\_

Do you experience yeast infections or urinary tract infections? Please explain: \_\_\_\_\_

### MEDICAL INFORMATION

Are you concerned with body image? Please explain: \_\_\_\_\_

Do you take any supplements or medications? Please list: \_\_\_\_\_

Do you have any healers, helpers, therapies, or pets? Please list: \_\_\_\_\_

What role does exercise, sports, and activities play in your life? \_\_\_\_\_

### FOOD INFORMATION

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



## Female Teen Health History

### FOOD INFORMATION (continued)

What is your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will family and/or 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 do you get the rest from? \_\_\_\_\_

Do you crave sugar, coffee, cigarettes, or drugs? Please explain? \_\_\_\_\_

The most important thing I should do to improve my health is: \_\_\_\_\_

### ADDITIONAL INFORMATION

Anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_