Women’s Health History Form

Please write or print clearly. All of your information will remain confidential between you and the Health Coach. Feel free to ask your health coach any questions you may have regarding this form.

Personal Information

First Name: ____________________________ M.I.:________ Last Name:_______________________________

Date of Birth: __________________________ Age: ________ Date of Health History: ___________________

Phone: Mobile: _______________________ Work: _______________________ Home: __________________

Email: ______________________________________ Preferred Contact Method: ________________________

Height: ____________ Current Weight: ___________ Wt. 6 months ago: ____________ 1yr ago:___________

Would you like your weight to be different? How? ____

Social Information

Relationship Status: ____

Where do you currently live? ____

# of Children: ____________________________________ Pets:_______________________________________

Occupation: ____ Hours of work per week: ________________

Health Information

Please list your main health concerns: ____

____

____

Other goals? ____

____

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

Any serious illnesses/ hospitalizations/ injuries? ____

____

How was/is your mother's health? ____

How was/is your father's health? ____

What is your blood type? ________________. How is your sleep? ___________________________________

How many hours do you get each night? ___________________ Do you wake up at night? ________________

If yes, why? ____

Any pain, stiffness or swelling? ____

____

Any digestive problems (constipation, diarrhea, gas, etc.)? ____

Allergies or sensitivities? Please explain: ____

Are your periods regular? _______________________ How long is your cycle? _________________________

Are your periods painful or symptomatic? If yes, explain: ____

Birth control history: ____

Do you experience yeast infections or urinary tract infections? _______________________________________

Do you have any diagnosed medical conditions? ____

Please list any medications or supplements you are taking: ____

____

____

Are there any other therapies or treatments that you are involved in? Please list: __________________________

____

How often do you exercise: ______ Never ______1-3x/month ______ 1-2x/week ______3-5x/week

Do you smoke? ______ Often ______ Sometimes ______ Never

Do you drink alcohol? ______ Often ______ Sometimes ______ Never

Do you eat fast food? ______ Often ______ Sometimes ______ Never

Food Information

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
________________	________________	________________	________________	________________
________________	________________	________________	________________	________________
________________	________________	________________	________________	________________

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? _______________

Do you cook? _________________________ What percentage of your food is home cooked? ________________

Where is the rest of your food from? ____

Do you have a specific concern(s) related to your diet/ nutrition? ____

Do you crave foods such as sugar, coffee, cigarettes, or have any major addictions? ________________________

____

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

____

What would you like to gain from working with a health coach? ____

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