# WOMEN'S HEALTH HISTORY

Your information will remain confidential between you and your Health Coach.

## PERSONAL

First Name: ______________________________

Last Name: ______________________________

Age:__________Height:______________Date of Birth: ______________________________

Email:______________________________

Mobile Phone: ____________________

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

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

## SOCIAL

Relationship Status: ______________________________

Where do you live? ______________________________

Any children?______________________________Any 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? ______________________________

______________________________

How is your sleep?______________________________How many hours do you sleep per night? ____________

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

Any pain, stiffness, or swelling? ______________________________

Any constipation, diarrhea, or gas? ______________________________

Any allergies or sensitivities? ______________________________

## WOMEN'S HEALTH

Are your periods regular?_________How many days is your flow?____________________How frequent? ________________________

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

Have you reached or are you approaching menopause? If so, please explain: ______________________________________

What is your birth control history? ____________________________________________________________________

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

## MEDICAL

List all supplements or medications: ___________________________________________________________________

______________________________________________________________________________________________

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

______________________________________________________________________________________________

How often do you exercise/play sports? ______________________________________________________________

# WOMEN'S HEALTH HISTORY

## FOOD

Do you cook? ____________ What percentage of your food is home-cooked? ____________

What foods do you typically eat in a week?

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Do you crave sugar, coffee, salt? ____________

Have you tried any diet programs in the past?____________

## ADDITIONAL COMMENTS:

Is there anything else you would like to share?

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