Restorative Health & Wellness

WOMEN'S HEALTH HISTORY

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

PERSONAL DEMOGRAPHICS:

First Name: _____

Last Name: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Email: _____ How often do you check your email? _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

SOCIAL HEALTH:

Relationship Status: _____

Where do you live? _____

Any children? (if yes, how many?) _____Any pets?(if yes, how many?) _____

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

MEDICAL HEALTH:

Do you have any current medical issues/concerns? _____

_____

_____

Any you currently undergoing any treatments, therapies or under a physicians care for anything? _____

_____

Any current or previous hospitalizations, or injuries? _____

_____

List all supplements, and/or medications: _____

_____

Any allergies or sensitivities to food or medications? _____

Current weight?_____Weight six months ago?_____Weight one year ago? _____

What is your blood type? _____

WOMEN'S HEALTH HISTORY

GENERAL HEALTH:

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? _____

FAMILY HISTORY:

How your mother's health? Any serious health issues?_____

How's your father's health? Any serious health issues?_____

What's your ancestry?_____

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: _____

FOOD HISTORY:

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

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

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

WOMEN'S HEALTH HISTORY

FOOD HISTORY: (continued)

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you crave sugar, coffee, or cigarettes? Any other major addictions?_____

What is the most important thing you should change about your diet to improve your health? _____

_____

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? _____

_____

ADDITIONAL QUESTIONS:

What role if any does exercise play in your life? _____

_____

What are your health and wellness goals? _____

_____

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

_____

_____

Is there anything else you would like to share? _____

_____

_____