Whole Healthy Living

Transforming Lives Spirit, Soul & Body

Women's Health History

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

PERSONAL INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____ _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

SOCIAL INFORMATION

Relationship status: Single Married Significant Other Divorced Separated

You Lives in your Household: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

Please list your main health concerns: _____

_____

_____

_____

Other concerns and/or goals? _____

_____

_____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is your _____ How many hours? _____ Do you wake up at night? _____

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sleep? _____ _____ _____

Why ? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

Birth control history: _____

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

_____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

_____

_____

_____

Any healers, helpers, or therapies with which you are or have been involved? Please list:_____ _____

_____

What role does physical activity play in your life? Describe frequency/duration_____ _____

_____

What foods do you currently eat?

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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 do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

_____

How did you hear about my Health programs? _____

_____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

_____

_____