



Women's Confidential Health History

Please write or print clearly

Name: _____

Address: _____

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

Telephone – Work: _____ Home: _____ Cell: _____

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

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

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

Relationship status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

Other concerns? _____

Any serious illness/hospitalizations/injuries? _____

How is the health of your mother? _____

How is the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

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

Painful or symptomatic? _____ Please explain: _____

Birth control history: _____



Vaginal infections, reproductive concerns? _____

Constipation/Diarrhea/Gas? _____ Explain: _____

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

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

What role do sports and exercise play in your life? _____

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What's your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What percentage of your food is home cooked? _____ What percentage is not? _____

Where do you get the rest from? _____

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

Anything else you would like to share?