Women's Confidential Health History, Intake, and Evaluation

Please print clearly.

Name: ____________________________________ Date: _______________________

Address: ____

City: ____ State: ____ Zip: _________

Phone No. (best): _______________________ Alternative: _____________

Email: ____ Birth date: ______________

Birth Place: _____________________

Height: ____________Current Weight: __________ One Year Ago:____________

Would you like your weight to be different? Y / N (circle) If so, what?____________

Body Frame (S, M, L): _______ Relationship Status: _____________

Children and Ages: ____

Pets: ____

Family/Living Situation: ____

Occupation: ______________________ Full-time, Part-time, Other: __________

Exercise/Recreation and # of times/week: ____________________________________

Ancestry:________________________ Blood Type:_______________

Do you sleep well? ___________How many hours?_________ Do you wake up?______

Why?____

Health Concerns and Goals

Please describe your main health concerns and goals. Other concerns and goals?

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

Any serious illnesses/hospitalizations/injuries?

How is/was the health of your mother and father?

Have any other family members had similar health concerns (describe)?

What other health practitioners, healers, helpers, or therapists are you currently seeing (name, specialty, phone #)?

Please list all medicine or supplements you are currently taking:

How has your diet changed in relationship to your health concerns/goals? (Special diets?)

Do you have any pain/stiffness/swelling?

Are your periods regular? Y / N (circle) How many days is your flow?___________

How frequent? ___________________ Painful or symptomatic? Please explain:

Reached or approaching menopause? Please explain:

Birth control history:

Are you breastfeeding?

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

Constipation/diarrhea/gas? Please explain:

Allergies or sensitivities? Please explain:

How are your moods in general? Do you experience more anxiety than you wish? Depression? Anger?

Health Hazards
Describe any sources of stress in your life (work, family, relationships, financial, physical).

List any known toxic exposures (tap water, air pollution, job and home exposures, cosmetics, food and chemical residues, e.g., Nutrasweet, and medicines including aspirin, birth control, etc.).

List any trauma (unresolved, physical and/or emotional wounds or abuse). What re-stimulates it? How does it affect your diet and health habits?

Describe any mal-nutrition (periods of eating junk food, binge eating, dieting).

List any addictive behaviors (past or present use and abuse of alcohol, drugs, tobacco, caffeine, co-dependency, workaholic, etc.). Do you crave sugar, caffeine, alcohol, cigarettes, or have any major addictions?

Dietary Habits and Choices
What role do sports and exercise play in your life?

What were your diet and family eating habits like growing up?

What is your diet like now? Breakfast, Lunch, Snacks, Dinner and Liquids?

Describe the foods you eat (comfort foods) when you are:

Hungry:

Angry:

Lonely:

Tired:

Depressed:

Celebrating:

How is your mood and energy level affected by eating these foods (nourishing or numbing)?

On a scale of 1 to 10, 1 being the worst and 10 being the best, describe your usual level of energy (circle one):

1 2 3 4 5 6 7 8 9 10

Will family and friends be supportive of your desire to make healthy food and lifestyle choices?

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

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

Anything else you would like to share?