office@nutrition101.org

Women's Confidential Health History

Please write or print clearly.

Name: _____

Address: _____

Email, or other contact info: _____ What is the best way to contact? _____

Telephone _____ Cell: _____

Age: _____ Height: _____ Blood type: _____

Current weight: _____ Desired weight: _____ Maximum weight: _____

Relationship status: _____

How many children? _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

_____

_____

_____

_____

_____

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

Any serious illnesses/hospitalizations/injuries; (e.g. gallbladder, tonsils…)? _____

_____

_____

_____

Family history of illnesses: _____

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

Why poor sleep? _____

Do you have stress? _____

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

Painful or symptomatic? Please explain: _____

How many meals do you eat per day?	
How many snacks?	
How many times per day do you feel hungry?	
What food cravings do you have?	
How many fast food meals per week?	

Do you use hormonal birth control?: _____

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

Constipation/Diarrhea/Bloat/Gas? explain: _____

Number of Bowel Movements: _____ / Day Wk (circle one); Floating stools? Y / N; Light Colored? Y / N

Allergies or sensitivities? Please explain: _____

Do you take any supplements, drugs, or medications? Please list:

Drug or Supplement Name	**Strength**	**How often**	**Date started**

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

_____

Describe a typical meal for an average day.

Breakfast	Lunch	Dinner	Snacks	Liquids

Other comments _____

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

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

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

_____

The most important thing I should change about my diet to improve my health is: _____

_____

_____

_____

Food Frequency Assessment

How often do you eat this food:	Daily	Weekly	Monthly
Coffee/black tea			
Soda			
Alcohol			
Tap water			
Bottled juice / sport drinks			
Bread products			
Pasta			
Cereal			
Cookies			
Chips			
Candy			
Margarine/mayonnaise			
Cheese			
Milk			
Ice Cream			
Peanut Butter			
Eggs			
Fried Foods			
Red Meat			
Poultry			
Fish			
Beans/Legumes			
Filtered Water			
Herb Teas			
Fresh Juices			
Fruit			
Vegetables			
Salad Greens			
Dark leafy Greens			
Whole grains			
Nuts/seeds			
Olive oil			
Sea vegetables			
Tofu/tempeh			
Yogurt			

Symptom Questionnaire

What conditions have you been diagnosed with?	
Do you have any digestive problems?	
How frequent are bowel movements?	
Joint pain or swelling?	
Frequent leg cramps?	
Anxiety or depression?	
Did you have post partum depression?	
Hyper / Hypo thyroid symptoms?	
Hypertension / High Blood Pressure	

Disclaimer: I am not a licensed healthcare practitioner, and provide only non-medical advice regarding lifestyle or dietary advice. I work as a coach to help a client meet his/her goals. As a consultant in health related topics, I do not diagnose or treat any condition. Speak with your doctor before using any supplement, diet, or other lifestyle intervention that I may discuss with you. Health coaching is not required to be licensed by the State.

Name: _____ Date: _____