Women's Confidential Health History

Please write or print clearly

Name: _____

Address: _____

Email address: _____

Cell/Home: _____

Age: _____ Height: _____ Date of Birth: _____

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

Highest adult weight: _____ Lowest adult weight: _____

Do you weigh yourself currently? If yes, how frequently? _____

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

Please circle how you currently feel about your body.

Strongly dislike Dislike Slightly satisfied Satisfied Very satisfied

Relationship status: _____

Children: _____

Pets: _____

Occupation: _____

Hours of work per week: _____ Typical times for work in a day: _____

Time you wake up in the morning: _____ Time you go to bed at night: _____

Do you sleep well: _____ How many hours: _____

Do you wake up at night: _____ If yes, why: _____

Any serious illnesses/hospitalizations/injuries: _____

_____

How is the health of your father: _____

How is the health of your mother: _____

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

Any pain, stiffness, or swelling: _____

If applicable, are your periods regular: _____How many days is your flow: _____How frequent: _____

Painful or symptomatic, please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections, please explain: _____

_____

If applicable, how much weight did you gain with pregnancy(s): _____

Constipation/Diarrhea/Gas, please explain: _____

Allergies, food intolerances, sensitivities: _____

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

_____

Any healers, helpers or therapies with which you are involved: _____

_____

What role does sports and exercise play in your life: _____

Have you ever had a consistent exercise routine: _____

Are you following one currently, if yes, please describe: _____

_____

Do you travel and/or entertain for business: _____ If yes, how often: _____

Tell me about your dieting history (types of diets, amount of weight lost, short/long-term results, etc.): _____

_____

How many meals a day do you eat: _____ Do you skip meals: _____ If yes, which ones and why:

_____

What are your snacking habits (frequency, time of day, foods you choose): _____

_____

Do you cook: _____

Do you like to cook: _____ Who prepares the food at home: _____

How many meals per week do you eat at a restaurant: _____

Which restaurants do you normally choose: _____

How does your meal and snack pattern vary on the weekend vs. during the week: _____

_____

When you feel overwhelmed or life gets busy, do you neglect your eating habits: _____

If yes, please describe: _____

Do you feel that your life/schedule often conflicts with a healthy eating program? _____

If yes, please describe: _____

Do you engage in other activities while eating (reading, driving, watching TV): _____

Do you eat at the table: _____ Do you feel you eat fast: _____

Who does the grocery shopping: _____

Do you read food/nutrition labels: _____

If yes, what do you look for on labels: _____

Please list the usual time that you eat the following meals and your typical daily intake for each meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What foods do you love: _____

What foods do you dislike: _____

Are there any foods that feel like binge foods for you: _____

Are there any foods that feel “safe” to you: _____

Does your diet have a lot of variety or does it tend to be the same from day to day: _____

Please share any illicit drug, alcohol, cigarette use: _____

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes: _____

Do you have a strong support system, Please describe: _____

_____

Have you ever been advised by your physician to follow a special diet (i.e. low salt/cholesterol, no sugar, etc):

_____

Please list your main health concerns: _____

_____

Please list your health goals: _____

_____

Have you ever worked with a dietitian/nutritionist: _____

If yes, what was your experience: _____