



{ One Girl Wellness }

Raising stronger women one girl at a time | onegirlwellness.com

Women's Health History

All information will remain confidential between you and your health coach.

PERSONAL INFORMATION

First Name

Last Name

E-mail

How often do you check email?

Home Phone:

Work:

Mobile:

How would you prefer to be contacted:

What forms of social media do you use?

Email

Facebook

Instagram

Mobile

Twitter

LinkedIn

Text

Pinterest

Google+

Other

Would you be interested in participating in a privacy-protected online forum to discuss issues that are important to you?

Yes

No

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PERSONAL INFORMATION (continued)

Age Height Birthdate Place of Birth

Current weight Weight 6 months ago One year ago

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

SOCIAL INFORMATION

Relationship Status Where do you currently live?

Children Pets Occupation Hours of work per week

HEALTH INFORMATION

Please list your main health concerns

Other concerns and/or goals

At what point in your life did you feel best?

HEALTH INFORMATION (continued)

Any serious illnesses/hospitalizations/injuries?

How was/is the health of your mother?

How was/is the health of your father?

What is your ancestry?

What blood type are you?

How is your sleep?

How many hours?

Do you wake up at night?

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:

WOMEN'S HEALTH (continued)

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 involved? Please list:

What role do sports and exercise play in your life?

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FOOD INFORMATION

What foods did you eat as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

What is your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

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

Yes

No

I'm not sure

Do you cook?

What percentage of your food is home-cooked?

Yes

No

Where do you get the rest from?

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

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

ADDITIONAL COMMENTS

Anything else you would like to share?