Confidential Health History (Women)

Name:

Address:

Email address: *Telephone:*

Who referred you to us?

Age: *Date of Birth:* *Place of Birth:*

Relationship status:

Children: *How many pregnancies?*

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

Would you like your weight to be different?

Occupation:

Hours of work per week:

Are you happy with your job?

Please list your main health concerns:

Other concerns?

Any serious illness/hospitalizations/injuries/surgeries? Please list all, including in your childhood.

Do you have any metal in your body (stents, implants, etc.) or a pacemaker?

Do you have any metal fillings in your teeth? *If yes, how many?*

Any root canals or implants?

Have you travel outside of US? *When and where?*

Have you been sick while traveling?

How is the health of your mother? *Age:*

How is the health of your father? *Age:*

What is your ancestry?

What blood type are you? (If you don't know it, don't worry about it)

How is your energy level?

When did you get your first period? *Are you in menopause?* *If yes, since when?*

Are your periods regular? *Painful or symptomatic?*

Birth control history:

Vaginal infections, yeast infections?

Any other reproductive organs issues/concerns?

Have you notice the drop in your libido?

Do you sleep well? *How many hours?*

Do you wake up at night? *Why?*

Any pain, stiffness or swelling?

Any digestive issues? (Constipation/Diarrhea/Gas, heartburn, etc)

Explain:

Any skin issues?

Do you have any known or suspected allergies or sensitivities?

What makes then worse?

Do you take any supplements or medications? Please list:

Any healers, helpers, or therapies you have tried? Please list:

What role do sports and exercise play in your life?

Which foods did you eat often as a child?

What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

Do you drink alcohol, what kind and how much?

Do you smoke or have ever smoked?

Do you drink coffee and how much?

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?

Do you feel depressed or sad often?

Have you ever taken any medication for that?

What are the things in life you do that make you happy?

Have you had major trauma in your life and when (death or illness in the family, parent's or your own divorce, job loss or change, major move, etc.)?
(Please list all and the year when it happened). If you prefer to discuss it in person, that is totally ok.

How would you rate your health on a scale 1 to 10?

How are you satisfied with you overall appearance presently on a scale 1 to 10?

Anything else you would like to share?

What would you like to improve in your health to make you function to the fullest potential? (List in order of priority)

1
2
3

Add more if you need

Thank you!

Important!

Please bring all the supplements and medications you are currently taking, in the original bottles for your initial appointment.

- On the day of your appointment take only the medication what is prescribed by a doctor.
- If you have the latest blood work, bring it with you.
- Do not use cologne, perfume, essential oils or anything with a fragrance before the appointment.
- Do not eat 2 hours before your appointment but drink plenty of water.
- Do not drink alcohol 24 hours prior to your appointment.