



Confidential Health History Questionnaire for Women

Please write or print clearly, and return it 48hrs hours before our appointment

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Phone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight 6 mo ago: _____ One year ago: _____

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

Relationship status: _____

Name of spouse/partner: _____

Children?: _____ Pets?: _____

Occupation: _____ Hrs of work/wk: _____

Hobbies & Activities: _____

What is your ancestry? _____ Blood type (if known): _____

Referred by: _____



Please list any prescription or non-prescription medications you use; Include brand names and dosage.



Main health concerns: _____

Other concerns / goals? _____

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

SLEEP, ENERGY & STRESS

Do you sleep well? _____ How many hours? _____ Typical time to bed: _____ Typical time to wake: _____

How long does it take you to fall asleep? _____ If woken during the night, can you fall back to sleep easily? _____

Do you wake up at night? _____ If so, why? _____ At what time? _____

How do you feel when you wake up? _____

Is your room completely dark when you sleep? (no night light, street lamp, TV, bright clock displays, etc.) _____

Do you get at least 30 minutes of outside daylight time, several days each week? _____

Describe your energy pattern throughout the day. _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How would you rate your stress handling? (1=Poor, 10=Strong) 1 2 3 4 5 6 7 8 9 10



Do you have any digestive issues?

Please explain:

Do you experience discomfort (pain, gas, bloating, heartburn, nausea) after eating? Please explain:

of bowel movements per day:

Do you ever experience constipation or diarrhea? Please explain:

Any known food allergies or sensitivities? Please list:

Age of your first period: _____

Are/were your periods regular? _____

Have you entered menopause? _____

If so, at what age? _____

How many days is/was your flow? _____

How long are/were your monthly cycles? _____

If/when cycling, do/did you experience PMS?
If yes, please describe symptoms

Birth control history: _____

How many children have you delivered and how were they born? (vaginally/C-section)

Were there complications associated with these births? Please explain:



Did you receive antibiotics during labor? _____

Have you had difficulty conceiving? _____

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

If post-menopausal, describe your transition into menopause, including any symptoms _____



What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What % of your food now is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

How much water do you drink per day? _____

Do you drink caffeinated drinks? _____ Which ones, how much, and how often? _____

Do you drink alcoholic drinks? _____ Which ones, how much, and how often? _____

Do you drink soda (diet or reg)? _____ Which ones, how much, and how often? _____

Do you crave sugar, coffee, cigarettes, _____



or have any major addictions? _____

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

Describe your weekly cardio training routine:

Exercise	Intensity	Duration	# times/week
_____	_____	_____	_____
_____	_____	_____	_____

Describe your weekly strength training routine:

Exercise	Intensity	Duration	# times/week
_____	_____	_____	_____
_____	_____	_____	_____

Describe any other exercises / sports / physical activities you do:

Exercise	Intensity	Duration	# times/week
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? _____ How much and how often? _____

If you used to smoke but quit – why, how and when did you quit smoking? _____

Are you exposed to second-hand smoke? _____ How much and how often? _____

Have you been exposed to toxic substances at work or home? _____

Do you have mercury fillings? _____ Do you plan to have them removed? _____



Family health history

How is your mother's health? _____

How is your father's health? _____

Has a **blood-related** family member of yours had any of the following health conditions? If yes, please indicate if it was their cause of death and specify their relationship to you (mother, father, sibling, maternal or paternal grandparent).

Alzheimer's _____ Relationship to you: _____

Asthma _____ Relationship to you: _____

Autoimmune disease (specify type) _____ Relationship to you: _____

Cancer (specify type) _____ Relationship to you: _____

COPD _____ Relationship to you: _____

Dementia _____ Relationship to you: _____

Diabetes (specify type) _____ Relationship to you: _____

Emphysema _____ Relationship to you: _____

Epilepsy _____ Relationship to you: _____

Gall bladder condition _____ Relationship to you: _____

Glaucoma _____ Relationship to you: _____

Heart attack (specify type) _____ Relationship to you: _____

Heart condition (specify type) _____ Relationship to you: _____

High blood pressure _____ Relationship to you: _____

Kidney disease _____ Relationship to you: _____



Liver disease
Mental illness
(specify type)

Relationship to you:

Relationship to you:

Migraines

Relationship to you:

Obesity

Relationship to you:

Osteoarthritis

Relationship to you:

Osteoporosis

Relationship to you:

Parkinson's disease

Relationship to you:

Rheumatoid arthritis

Relationship to you:

Stroke

Relationship to you:

Thyroid condition
(specify type)

Relationship to you:

Ulcer (specify type)

Relationship to you:

Other

Relationship to you:

Other

Relationship to you:

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

Have you tried addressing your current health concerns in the past?

If yes, what happened? _____

Do you feel ready to make the changes necessary to achieve your health goals? _____

Anything else you want to share? _____



EMERGENCY NOTIFICATION:

Name: _____

Address: _____

Email address: _____ Phone: _____