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.

_____ _____

_____ _____

_____ _____

Please list any vitamins/minerals/herbs/homeopathic remedies, diet pills, or any other supplements you use; Include brand names and dosage.

Please list any known allergies to medications or herbs:

Please list any surgeries, accidents, injuries, hospitalizations, or childhood diseases you have had along with the type and date:

Are you currently under a practitioner's care for a specific health issue? If so, what treatments are you receiving?

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

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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		Relationship to you:	
Mental illness (specify type)		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: _____