Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

|  |  |
| --- | --- |
| First Name:  |   |

|  |  |
| --- | --- |
| Last Name: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |  | How often do you check email? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: Home: |  | Work: |  | Mobile: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Age: |  | Height: |  | Birthdate: |  | Place of Birth: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current weight: |  | Weight six months ago: |  | One year ago: |  |

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

|  |  |
| --- | --- |
| Why did you come for a Health History? |  |

SOCIAL INFORMATION

|  |  |
| --- | --- |
| What is your relationship status? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What grade are you in? |   | Do you enjoy school? Please explain: |  |
|  |  |

|  |  |
| --- | --- |
| Do you have a large or small group of friends? |   |

HEALTH INFORMATION

|  |  |
| --- | --- |
| Please list your main health concerns: |   |
|  |  |

|  |  |
| --- | --- |
| Other concerns? |  |

|  |  |
| --- | --- |
| Any serious illnesses/hospitalizations/injuries? |  |
|  |  |

|  |  |
| --- | --- |
| How is/was the health of your mother? |  |

|  |  |
| --- | --- |
| How is/was the health of your father? |  |

|  |  |
| --- | --- |
| Where do your parents and grandparents come from? |  |

HEALTH INFORMATION (continued)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How is your sleep? |  |  How many hours? |  | Do you wake up at night? |  |

|  |  |
| --- | --- |
| Why? |  |

|  |  |
| --- | --- |
| Constipation/Diarrhea/Gas? |  |

|  |  |
| --- | --- |
| Allergies or sensitivities? Please explain: |  |

FEMALE TEEN HEALTH

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are your periods regular? |  | How many days is your flow? |  | How frequent? |  |

|  |  |
| --- | --- |
| Painful or symptomatic? Please explain: |  |

|  |  |
| --- | --- |
| What is your birth control history? |  |

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

MEDICAL INFORMATION

|  |  |
| --- | --- |
| Are you concerned with body image? Please explain: |   |
|  |  |

|  |  |
| --- | --- |
| Do you take any supplements or medications? Please list: |  |

|  |  |
| --- | --- |
| Do you have any healers, helpers, therapies, or pets? Please list:  |  |
|  |  |

|  |  |
| --- | --- |
| What role does exercise, sports, and activities play in your life? |  |
|  |  |

FOOD INFORMATION

|  |
| --- |
| What foods did you eat often as a child?  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

FOOD INFORMATION (continued)

|  |
| --- |
| What is your food like these days? |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What percentage of your food is home-cooked? |  | Do you enjoy the food? |  |

|  |  |
| --- | --- |
| Where do you get the rest from? |  |

|  |  |
| --- | --- |
| Do you crave sugar, coffee, cigarettes, or drugs? Please explain? |  |
|  |  |

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

ADDITIONAL INFORMATION

|  |  |
| --- | --- |
| Anything else you would like to share? |  |
|  |  |
|  |  |
|  |  |