PARAVIDA Wellness

Women's Health History

Please write or print clearly. All of our information will remain confidential between you and ParaVida Wellness health coaches.

PERSONAL INFORMATION

First Name _____

Last Name _____

Email Address _____ How often do you check email? _____

Phone Number _____ Work Number _____ Cell _____

Age _____ Height _____ Birthdate _____ Place of Birth _____

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? _____ Pets _____

# of Children _____ Children's Name _____

Occupation _____ _____ Hours of Work per week _____

HEALTH INFORMATION

Please list your main health concerns _____

_____

_____

Other concerns or goals? _____

_____

_____

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

_____

Any serious illnesses/hospitalization/injuries? _____

_____

_____

PARAVIDA Wellness

Women's Health History

HEALTH INFORMATION

How is/was the health of your mother? _____

How is/was 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? If so, please explain _____

_____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain _____

Reached or approaching menopause? Please explain _____

Birth control history? _____

Do you experience yeast infections or uniary tract infections? Please explain _____

_____

MEDICAL INFORMATION

Do you take supplements or medications? If so, please list _____

_____

_____

Any healers, helpers, or therapies with which you are involved? If so, please list _____

_____

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

_____

PARAVIDA Wellness

Women's Health History

FOOD INFORMATION

What foods did you eat often as a child?

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

What foods did you eat often now as an adult?

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

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

Do you cook? _____ What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

Do you crave sugar, caffeine, 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? _____

_____

_____

_____

_____