

FEMALE TEEN HEALTH HISTORY

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

PERSONAL

First Name: _____

Last Name: _____

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

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Current Weight: _____ Weight Six Months Ago: _____ Weight One Year Ago: _____

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

Why did you sign up for a Health History? _____

SOCIAL

What is your relationship status? _____

Do you have any pets? _____ What grade are you in? _____

Do you enjoy school? Please explain: _____

Do you have a large or small group of friends? _____

GENERAL HEALTH

What are your main health concerns? _____

Any other concerns? _____

Any serious illnesses, hospitalizations, or injuries? _____

How is/was your mother's health? _____

How is/was your father's health? _____

FEMALE TEEN HEALTH HISTORY

GENERAL HEALTH (continued)

What is your ancestry? _____

How is your sleep? _____ How many hours do you sleep per night? _____

Do you wake up during the night? If so, why? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

FEMALE TEEN HEALTH

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

Are your periods painful or symptomatic? If so, please explain: _____

What is your birth control history? _____

Do you experience yeast infections or urinary tract infections? If so, please explain: _____

MEDICAL

Are you concerned with body image? If so, please explain: _____

Do you take any supplements or medications? _____

Are you involved with any healers, helpers, or therapies? _____

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

FOOD

Will your family and 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 does your non-home-cooked food come from? _____

Do you crave sugar, coffee, cigarettes, or drugs? Do you have any other major addictions? _____

FEMALE TEEN HEALTH HISTORY

FOOD (continued)

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

What foods do you typically eat these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

What is the most important thing you should change about your diet to improve your health? _____

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____
