THRIVE
RESULTSCOACHING ©

Women's Confidential Health History

Please write or print clearly

Name: _____

Address: _____

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

Telephone – Work: _____ Home: _____ Cell: _____

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

Current weight: _____ Weight six months ago: _____ One year ago: _____

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

Relationship status: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

_____

_____

How often does it (your health complaint) bother you? _____

_____

What have you tried to far that has not worked? _____

_____

_____

Is there anything getting in the way? (bad habits, poor relationship, job stress etc) _____

_____

_____

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

_____

Other concerns: _____

On a scale of 1-10, how motivated are you to get healthy and reach your goals? _____

_____

What is the #1 Goal you would like to accomplish in the next 6 months? _____

_____

_____

What is the 2nd most important goal you would like to accomplish in the next 6 months? _____

_____

_____

What is the 3rd most important goal you would like to accomplish in the next 6 months? _____

_____

_____

Why would you like to achieve these goals? _____

_____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is/was the health of your father? _____

How is/was the health of your mother? _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

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 urinary tract infections? Please explain: _____

_____

Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

Do you take any supplements or medications? Please list: _____

_____

Any healers, helpers or therapies with which you are involved? Please list: _____

_____

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

_____

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's 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? _____

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

_____

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

Where do you get the rest from? _____

_____

The most important thing I should change about my diet to improve my health is: _____

_____

Have you ever worked with a Health Coach before? _____

What qualities would you like to have in a Coach? _____

Anything else you would like to share? _____