



**Women’s Confidential Health History**

Please type or print clearly. Complete & return form at least 48 hours prior to our appointment.

Email: [brendasmith@startwithnutrition.com](mailto:brendasmith@startwithnutrition.com) Phone: 860-368-0709

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: \_\_\_\_\_

Other concerns and/or goals? \_\_\_\_\_

At what point in your life did you feel best? \_\_\_\_\_

Any serious illnesses/hospitalizations/injuries? \_\_\_\_\_

How is the health of your mother? \_\_\_\_\_

How is the health of your father? \_\_\_\_\_

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: \_\_\_\_\_

Do you have any digestive issues? Do you experience pain/gas/bloating/heartburn after eating? Constipation/Diarrhea/Gas? Please explain: \_\_\_\_\_

Allergies or sensitivities? Please explain: \_\_\_\_\_

Any other medical conditions now or historically? Please list: \_\_\_\_\_

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?**

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____


What's your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>

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 cook? \_\_\_\_\_

Where do you get the rest from? \_\_\_\_\_

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

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

Anything else you want to share?

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