Female Teen Health History

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? ____________________

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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
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

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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?

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