integrative wellness advisors

Women's 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: _____

Address: _____

City: _____ State: _____ Zip: _____ 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? _____

SOCIAL INFORMATION

Relationship status: _____ Spouse name: _____

Children: _____ Children(s) name(s): _____

Where do you currently live? _____ Pets: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

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? _____

_____

integrative wellness advisors

Women's Health History

HEALTH INFORMATION (continued)

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? _____

What time do you wake up in the morning? _____ What time do you turn in for the night? _____ What time do you fall asleep? _____

How is your sleep (i.e., continuous, restful, restless)? _____

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

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

How many times per year to you get sick (cold, flu, virus)? _____

Allergies or sensitivities? 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 urinary tract infections? Please explain: _____

_____

MEDICAL INFORMATION

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

_____

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

integrative wellness advisors

Women's Health History

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

_____

FOOD INFORMATION

Please list what you eat (the most commonly eaten foods on a daily basis):

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or 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, 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? _____

_____

_____

_____

Toxicity QUESTIONNAIRE

INTEGRATIVE WELLNESS ADVISORS

The Toxicity Questionnaire is a short self-assessment that will help you determine how toxic your body is now, based on the symptoms or conditions you're experiencing. This is your toxicity score "base case."

You may find it helpful to take this questionnaire again every 1-3 months to determine what (if anything) has changed. This comparison will give you valuable information about how your body is reacting to changes in your diet and lifestyle over time.

Respond "yes" or "no" to each question (keep in mind: "maybe" counts as "yes") based on your experience for the past 60 days.

☐ Sugar cravings?
☐ Hunger that's difficult to satisfy?
☐ Low or inconsistent energy?
☐ Fatigue, especially after exercise?
☐ Constipation?
☐ Difficulty sleeping restoratively?
☐ Caffeine addiction?
☐ Bloating or gas?
☐ Reflux or heartburn?
☐ Irritable bowel?
☐ Difficulty losing weight?
☐ Binge eating or drinking?
☐ Fluid retention?
☐ Stuffy or runny nose, itchy nose or eyes?
☐ Chest congestion?
☐ Asthma or wheezing?
☐ Migraines or headaches?
☐ Ringing in ears?
☐ Depression?
☐ Anxiety?
☐ Mood swings?
☐ Irritation?
☐ Brain fog or difficulty with concentration?
☐ Distractibility?
☐ Skin problems, such as acne, rosacea, eczema, or rashes?
☐ Joint problems or pain?
☐ Muscle aches?

Total score _____ Today's date _____

integrative wellness advisors

WWW.INTEGRATIVEWELLNESSADVISORS.COM