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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: ______________________________

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? ______________

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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Female Teen Health History

HEALTH INFORMATION (continued)

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? ____________

Constipation/Diarrhea/Gas? ____________

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

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? ____________

____

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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? ______

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?______

______

______

______

Toxicity QUESTIONNAIRE

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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 ______________________

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