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? _____

Naturally Sara

Female Teen Health History

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

Naturally Sara

Female Teen Health History

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? _____

_____

_____

_____