<u>Women Health History Pure Intentions</u>   **http://mypureintentions.com**

Please fill this Confidential Health History form out and send it back to me 2-3 days PRIOR to your consultation. This will offer you the best value during our interview.

Name: ____ Date: ________________
DOB____________________
Address:____ Home # _________________ Cell # ______________
Email ____
Occupation: ________________________Hours/week _____ Employer: ________________________________
Name of partner/spouse: ___________________________________ Marital Status: ____________________
List the ages and names of your children and step children
____
____
Have you seen a Health Coach before? (Y/N) When? ____
How was the experience? ____
What is your primary health concern or main reason for coming today?
____
____
____
When did your symptoms or health concern start?
____
Describe your symptoms: ____
____
What seems to make it better? ____
What makes it worse? ____
Are there related symptoms? ____

List in order of importance other health problems/concerns that are troubling you:
*What do you feel/think is causing your health concern(s)?
1. ____________________________________ since: _____________causes*: ___________________________
2. ____________________________________ since: _____________causes*: ___________________________
3. ____________________________________ since: _____________causes*: ___________ ________________
4. ____________________________________ since: _____________causes*: _________________________ __

How would you describe your general state of health? Excellent good fair poor
How would you describe your parents' state of health? Excellent good fair poor (explain)
____
____

Are you currently under the care of any Health care practitioners & why? *(check all that apply)*
______Chiropractor ______Acupuncturist ______Massage therapist
______Physiatrist ______Physical Therapist ______Homeopath
______Medical Doctor ______Reiki ______Reflexology
______Allergist ______Oncologist ______Cardiologist
______Rheumatologist ______Gastroenterologist ______Dermatologist
______ Counselor/Psychotherapist
Other: ____
Date of last physical: __________________________

When do you last remember feeling really great? ____

How long do you think it'll take to improve your health concerns? _________________
*(**When you're thinking of how soon you want results, consider how long you've had the condition.**)*

Name of medical doctor: ________________________________ Tel: ________________
Have you had any accidents, conditions, illnesses, injuries, surgeries or hospitalizations which affected your health in such a manner that you've never been totally well since? Y/N

If so, please list the type of condition and the approximate date it occurred:
____
____

Have you had lab work done for the current concerns?   Were the results normal?
*(*Please bring any and all lab work you have to your Health History for me to review: Any labs related to this concern and any other routine labs your MD may have performed over the last 3 years*)*

Quite often my clients need lab work for data we will use for the healing journey. Are you willing to have more lab work done?   Yes _____ No ______
Occasionally insurance companies decline claims for non-traditional testing.
If this were the case with you; are you willing to pay out of pocket? Yes _____ No _____

Have you used or are you currently using any of the following? Indicate (Y/N), the name, frequency and length of time you have taken these:

- Laxatives - Antidiarrheal ____
- Antacid - bloating ____
- Antibiotics: ____
- Probiotics ____
- Corticosteroid creams or pills: ____
- Pain killers (aspirin, Tylenol, ibuprofen, narcotics, etc.): _____________________________________
- Thyroid medication: ____
- Iron, folate, B12 ____
- Hormone Replacement: ____
- Birth Control Pill (BCP): ____
- Sleeping aides: ____
- Recreational drugs: ____
- Nasal sprays/allergy pills: ____

Which medications (including over the counter medications) or supplements are you currently taking?
____
____
____

Have you ever had allergy testing done? ____________ Was it blood, stool or skin patch testing? ___________
Where there any allergies?
____
____

What is your height ___________ Weight _________
Weight 6 months ago __________ Weight 1 year ago _______________ Goal weight _____________

Any weight concerns? (now/past) (gained/lost)

____

What have you tried to gain/lose weight?

____

How many meals do you have/day? _________ Do you skip meals? ________________________________

Do you have any complaints with your digestion? ____
How often do you have a bowel movement? ____
Are your bowels ___ hard___ loose ___ combination___ neither (“regular”) _________________________

How is your sleep? __________________ Difficulty falling asleep?________ Waking in the night? _________
Bed time: _______ Rising time: _______ Do you feel rested when you wake up? ______________
How many hours of sleep do you get each night? _____
Are your sleep habits regular? ___________________________
How often do you wake in the night to urinate? ____________________________________
What else wakes you at night? ____
Any dreams (recurrent/not) or nightmares? _______________________________________

What’s your energy level (1-10; 10=high)? ____
Do you meditate or use relaxation techniques? ___________________ How often? _______ Results? _______
Have you tried Yoga or Tai Chi in the past? _________________ How often? __________ Results? _________

Do you enjoy your work? ____________________ Do you take vacations? ____________
Do you follow any religious or spiritual/peaceful practice? _______ Please specify:

____

____
What do you enjoy most in your life? ____
Do you have time for this? ____
What do you worry most about in life? ____

What is your stress level (1-10; 10==high)? _______What are the things that you find stressful in your life?

____
Is your Mom alive Y N How old is she now or was she when she passed? ______ What medical struggles did she have? ____
Is your Dad alive Y N How old is he now or was she when she passed? ______ What medical struggles did he have? ____
How many siblings do you have? _____ What is their health like?

____

____

Who lives with you? ______________________________ Are they supportive of you working with a health coach? ____
Are there any other family health conditions you worry may affect you? (Who had this?)

____

List types, ages and names of pets

____

What role does sports and exercise play in your life? _____________ What is your typical sports or exercise each week? ____

How many glasses of each do you have daily? (0-10)
Water ______ Coffee ______ Tea ______ Energy drink _____ Milk ______ Sports drink _____ Juice ______
Wine _____ Beer ______ Mixed drink ______
What percentage of your food is cooked at home? ______________%
Where do you get the rest from? ____
What is your typical
Breakfast ____
Lunch ____
Dinner ____
How does this vary from how you ate as a child? ____
Do you crave sugar, coffee, cigarettes, or have any major addictions? When?
____

What relationships in your life are satisfying? ____
____
Do you have any relationships that are challenging or difficult?
____
____
How would you describe your relationship(s) with your partner/ children/ parent(s) /employer? ____
____

Has there been any traumatic experience or major loss in your life? ___________________________________
____ Age at time of trauma: _____________
Where have you last traveled outside of Canada/US? ____
____When? ____________________________

Have you been exposed to toxic chemicals (from home/where you live/work: paints, industrial cleaners, pesticides, orchards, golf courses, water, etc)?
____
____
Have you ever been tested for toxins or heavy metals? ____
Have you ever lived in a home with smokers? If so, when? ____
Have you ever had silver fillings put in your teeth? If so, when? _______________________________________
Have you ever had silver fillings replaced? If so, when? ____

Have you ever had reactions to any vaccinations, medications, or supplements? If yes, what and when?
____
____
Do you use a method of birth control or protection? If so, what type do you use? _________________________
Have you suffered with recurrent yeast or skin infections? ________ what did you treat those with and when?
____
Are there any incidents of physical, emotional or sexual abuse in your past?
____
*Women: Are you still menstruating? ________ Every __ days x _____ days
Discuss pattern and if this is a concern for you:

:____

Have you ever had trouble getting pregnant or staying pregnant?

Is there anything else you would like to share?

Thank you for your time. This information is valuable to your health!