Female Teen Health History for Pure Intentions

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: ____________ Date of birth: _______
Address:____ ____________ How long have you lived here?_______________________________________
Cell phone # ____________________________ Home # ___________________________
Guardian's name ____ Tel # _________________________
List the ages and names of people who live with you
____
List types, ages and names of pets
____
If you work – what is your job? __________________________________Hours/week _____

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

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*: ________________________ __
When did your symptoms or health concern start?
____
Describe your major symptoms:
____
____
What seems to make it better? ____
What makes it worse? ____
Are there related symptoms? ____
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.

Grade? _______________ What is your favorite subject? ____
What do you not like about school? ___________________________________ What are your grades? _______
List your 3 closest friends and what you like about them:
1. ____ why like? _____________________________
2. ____ why like? _____________________________
3. ____ why like? _____________________________
Do you have a boyfriend or girlfriend? ______ Name _______________________ how long? ______________
Does he/she support you in your health goals? ____

Date of last physical: _________________________

Name of medical doctor: _______________________________ Tel: _______________
What's your energy level (1-10; 10=high)? _______________________________________

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 _____

Are you currently under the care of any Health care practitioners? *(check all that apply)*

______Chiropractor ______Acupuncturist ______Massage therapist
______Physiatrist ______Physical Therapist ______Homeopath
______Medical Doctor ______Reiki ______Reflexology
______Allergist ______Oncologist ______Cardiologist
______Rheumatologist ______Gastroenterologist ______Dermatologist
______ Counselor/Psychotherapist

Explain why____
Other: ____

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 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: ____

Have you ever had allergy testing done? ____________ Was it blood, stool or skin patch testing? ___________
Where there any allergies?
____
____
Have you ever taken Antibiotics? _______ When/Why/Length of treatment?
____
____
Please list any other medication(s) not mentioned above, the amount you're taking and the condition(s) it's for:
____

List vitamins/minerals/supplements/herbs/remedies you're taking, amount(s), and reason:

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?____
What do you see when you look in the mirror? ____
What do you love about yourself ____
What do you wish you could change about yourself? ____

Do you have any complaints with your digestion? ____
How often do you have a bowel movement? ____
Are your bowels ___ hard___ loose ___ combination___ neither ("regular") _____________________________
Have you ever had anal itching or fissures? ____

Do you get headaches? ______ How often? ____________ What do you take? __________________________
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? _____ Time you fall asleep? ____________
Time wake up? ____________ 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? _______________________________________

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 follow any religious or spiritual/peaceful practice? _______ Please specify:

What do you do for fun? ______________________________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?

Do you play any sports, instruments or any other activities?

Is there an activity you wish you COULD do but don't have time, money or experience to do?

Where do you see yourself in 5 years? ____

How many glasses of each do you have daily? (0-10)
Water ______ Coffee ______ Tea ______ Energy drink _____ Milk ______ Sports drink _____ Juice ______
Wine _____ Beer ______ Mixed drink ______
How many meals do you have/day? _________ Do you skip meals? _____________________________________
What percentage of your food is cooked at home? ______________%
Where do you get the rest from? ____

What is your typical
Breakfast ____________________________________ Snacks ___________________________________
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/Why?
____

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/siblings/parent(s)/friends/employer?
____
____
Have you ever been bullied by a friend, teacher, classmate, employer or family member?
____
____
Are there any incidents of physical, emotional or sexual abuse in your past?
____

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 reactions to any vaccinations, medications, or supplements? If yes, what and when?
____
____
Have you suffered with recurrent yeast or skin infections? ________ What did you treat those with and when?
____
When did you get your first period? _________ Every __ days x _____ days? How often do you change a pad or tampon? __________________ Do you get cramps? _________________________
Have you ever had to use medication to control your periods?_____________________________________
Do you use a method of birth control or protection? If so, what type do you use? _________________________
Have you had any pregnancies? ____

Is there anything else you would like to share?
____
____
____

Thank you for your time.