Please fill out this form, save, and email it to: lenka@flownaturalhealthcare.com

Women's Confidential Health History

Reset Form

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Name:		Age:	Today's Date: **03/09/2014**
Street Address:	City:	State:	Zip:
Email Address:	How often do you check email?		
Best Phone #:	Do you prefer communication by email or phone? ☐ Email ☐ Phone		
Date of Birth:	Place of Birth:		
Relationship Status:	Children:	Pets:	
Occupation:	Hours of work per week:		
Please list your main health concerns:			
Do you have any other concerns and/or goals?			
Height:	Weight:	Weight 6 months ago:	Weight 1 year ago:
Would you like your weight to be different? ☐ Yes ☐ No	If yes, what would you like it to be?		
What is your ancestry?	What blood type are you?		
Will family and friends be supportive of your desire to make food/lifestyle changes?			
At what point in your life did you feel best?			
List any serious illnesses, hospitalizations, or injuries:			

Women's Confidential Health History (continued)

How is/was the health of your mother?		
How is/was the health of your father?		
Do you sleep well?		How many hours?
Do you wake up at night? ☐ Yes ☐ No	If yes, why?	
Are your period regular? ☐ Yes ☐ No	How many days is your flow?	How frequent?
Do you experience painful or heavy periods or PMS?		
Have you reached or are approaching menopause?		Use of birth control pills?

Do you experience any of the following:

Digestive issues such as pain, gas, bloating, heartburn, constipation, or diarrhea?

Allergies or sensitivities?

Pain, stiffness, or swelling?

Cravings for sugar, coffee, cigarettes, or have any major addictions?

Any other medical conditions currently or historically? Please list:

Are you receiving care from any health care professionals?
(physician, naturopath, chiropractor, acupuncturist, massage therapist, etc)

What role do sports and exercise play in your life?

Women's Confidential Health History (continued)

Do you take any supplements or medications? ☐ Yes ☐ No

If Yes, please list:

What foods did you eat often as a child?

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What foods do you eat today?

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What percentage of your food is home cooked?	Do you cook?

Where do you get the rest from?

The most important thing I feel like I need to change about my diet to improve my health is:

Please type in your full name below. This will act as your e-signature.

Signature:	Date: