Pilates Plus WELLNESS CENTER
301-952-1111 | 973-498-6955 (fax) | www.pilatespluscenter.com

WOMEN'S HEALTH HISTORY

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

PERSONAL

First Name: _____

Last Name: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Email: _____ How often do you check your email? _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Current Weight: _____ Weight Six Months Ago: _____ Weight One Year Ago: _____

Would you like your weight to be different? _____ If so, how? _____

SOCIAL

Relationship Status: _____

Where do you live? _____

Any children? _____ Any pets? _____

Occupation: _____ How many hours do you work per week? _____

GENERAL HEALTH

What are your main health concerns? _____

_____

_____

Any other concerns and/or goals? _____

_____

_____

At what point in your life did you feel your best? _____

Any current or previous serious illnesses, hospitalizations, or injuries? _____

_____

How is/was your mother's health? _____

How is/was your father's health? _____

What is your ancestry? _____ What is your blood type? _____

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WOMEN'S HEALTH HISTORY

GENERAL HEALTH (continued)

How is your sleep? _____ How many hours do you sleep per night? _____

Do you wake up during the night? If so, why? _____

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Are your periods painful or symptomatic? If so, please explain: _____

Have you reached or are you approaching menopause? If so, please explain: _____

What is your birth control history? _____

Do you experience yeast infections or urinary tract infections? If so, please explain: _____

MEDICAL

List all supplements or medications: _____

_____

Are you involved with any healers, helpers, or therapies? _____

_____

What role do sports and exercise play in your life? _____

FOOD

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? _____

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

Where does your non-home-cooked food come from? _____

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

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WOMEN'S HEALTH HISTORY

FOOD (continued)

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you crave sugar, coffee, or cigarettes? Do you have any other major addictions? _____

What is the most important thing you should change about your diet to improve your health? _____

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____