Divine Love Institute™
A Center for Empowerment

Nancy Livingston
Office (954) 920-0050
NancyL@DivineLoveInstitute.org

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Women's Health History Form

All of your information will remain confidential between you and the Health Coach.

Personal Information

First Name* _____ Last Name* _____

Address _____ Suite/Apt _____

City _____ State _____ Zip _____

Email* _____ How often do you check e-mail? _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Age _____ Height _____ Date of Birth ____ / ____ / _____ Place of Birth _____

Current weight _____ Weight six months ago _____ One year ago _____

Would you like your weight to be different? ☐ Yes ☐ No If yes, please explain:

Relationship status _____

Children _____ Pets _____

Occupation _____ Hours of work per week _____

Health Information

Please list your main health concerns:

Other concerns and/or goals?

At what point in your life did you feel best?

Any serious illnesses/hospitalizations/injuries? ☐ Yes ☐ No If yes, please explain:

How is/was the health of your mother?

How is/was the health of your father?

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

Do you sleep well? ☐ Yes ☐ No How many hours? _____

Do you wake up at night? ☐ Yes ☐ No If yes, please explain:

Any pain, stiffness or swelling? ☐ Yes ☐ No If yes, please explain:

Are your periods regular? ☐ Yes ☐ No How many days is your flow?_____ How frequent?_____

Are your periods painful or symptomatic? ☐ Yes ☐ No If yes, please explain:

Reached or approaching menopause? If yes, please explain:

Birth control history:

Do you experience yeast infections or urinary tract infections? ☐ Yes ☐ No If yes, please explain:

Constipation/Diarrhea/Gas? ☐ Yes ☐ No If yes, please explain:

Allergies or sensitivities? ☐ Yes ☐ No If yes, please explain:

Medical Information

Do you take any supplements or medications? If so, please list:

Any healers, helpers or therapies with which you are involved? If so please elaborate:

What role does sports and exercise play in your life? Please explain:

Food Information

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What's 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? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No What percentage of your food is home-cooked? _____ %

Where do you get the rest of your food from?

Do you crave sugar, coffee, cigarettes, or have any major addictions? ☐ Yes ☐ No If yes, please explain:

The most important thing I should do to improve my health is:

Additional Comments:

Anything else you would like to share?:

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