Health Thyme
TRANSFORM YOUR HEALTH

FEMALE TEEN 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 6 Months ago: _____ Weight 1 Year ago: _____

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

Why did you sign up for a Health History? _____

SOCIAL

What Relationship Status: _____

Do you have any pets? _____ What grade are you in? _____

Do you enjoy school? Please explain: _____

_____

Do you have a large or small group of friends? _____

GENERAL HEALTH

What are your main health concerns? _____

_____

_____

Any other concerns? _____

_____

_____

FEMALE TEEN HEALTH HISTORY

GENERAL HEALTH (Continued)

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? _____

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

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

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

FEMALE TEEN HEALTH

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

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

_____

What is your birth control history? _____

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

_____

_____

MEDICAL

Are you concerned with body image? If so, please explain: _____

_____

Do you take any supplements or medications? _____

_____

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

_____

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

_____

FEMALE TEEN HEALTH HISTORY

FOOD

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

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

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

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquid

What foods do you typically eat these days?

Breakfast	Lunch	Dinner	Snacks	Liquid

Do you crave sugar, coffee, cigarettes or drugs? 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?