**NISHA TOPPIN – WOMEN’S HEALTH COACHING**

Health History Form

Thank you for taking the time to fill out this form and provide me with details of your health, goals and medical history. You can save this form to your computer and type in your answers, then email back to me. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need. All questions are optional, but the more information you can give me, the better a holistic picture I can build up.

**Client Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code/Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (landline)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (mobile/cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by/ How Did You Find Me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statistics**

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ideal Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight One Year Ago \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family/Living Situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you (or could you be) pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise/Recreation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP/ Primary Care Provider Details**

GP Name:

GP Address:

GP Phone number:

**Health Concerns**

Please list your main health concerns in order of importance and describe in detail, including severity of the symptoms and duration:

1.

2.

3.

4.

5.

What are the three most important benefits or goals you hope to achieve?

1.

2.

3.

How do you want your overall health to be?

How motivated are you to modify your diet and lifestyle in order to improve your health (on a scale of 1-10, 1 being low motivation and 10 being totally committed)?

When did you first experience these health concerns?

How have you dealt with these concerns in the past? Please give details -

□ doctors

□ self-care

□ other

Have you experienced any success with these approaches?

Have any other family members had similar problems (describe)?

What other health practitioners are you currently seeing? List name and specialty.

List any medicine you are currently taking and dosage:

If you take medication, are you doing it under the supervision of a doctor? What kind of doctor?

List all vitamins, minerals, herbs and nutritional supplements you are now taking. Please give details of the condition being treated, dose, brand, frequency & duration. You can continue on a separate sheet if necessary.

Have you had any recent health tests? Please specify and attach results, if appropriate:

Please list the date and description of any recent surgical procedures you have had.

Have you had any other major surgery, biopsies, diagnosed conditions, significant periods of ill health, or do you suffer from allergies, chronic or niggling health problems? Please give details e.g. high blood pressure, cholesterol, frequent colds, recurrent infections etc.

How often did you take antibiotics in infancy/childhood, as a teen, and as an adult? Please state when and why you last took antibiotics plus any previous times you can remember:

Do you suspect your symptoms relate to a particular event or time in your life?

**Diet and Nutritional Status**

What are the three most Healthy foods/ drinks that you consume?

1.

2.

3.

What are the three most Unhealthy foods/drinks that you consume?

1.

2.

3.

Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:

Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

Are there foods that you crave? If so, please explain:

Describe your diet at the onset of your health concerns:

Do you have any known food allergies or sensitivities?

Which of the following foods do you consume regularly?

□ Alcohol

□ Artificial sweeteners

□ Sweets

□ Carbonated beverages/ Diet soda

□ Cigarettes, Chewing tobacco, Cigars/pipes

□ Coffee

□ Eat fast food regularly

□ Fried foods

□ Luncheon meats/ hot dogs

□ Margarine

□ Milk products, Dairy (milk, cheese, yoghurt)

□ Non-herbal tea

□ Refined flour/ Baked goods (gluten, wheat, barley, rye)

□ Refined sugar

□ Vitamins and minerals

□ Water, distilled

□ Water, Tap

□ Diet often

Are you currently on a special diet?

□ autoimmune paleo (AIP)

□ SCD/GAPS

□ dairy restricted or dairy-free

□ vegetarian

□ vegan

□ paleo

□ blood type

□ raw

□ refined sugar-free

□ gluten-free

□ other (please describe)

If you follow a specific diet, why did you decide to try it?

How long have you been doing it?

What do you eat on a typical day?

Have you noticed any changes in your health or symptoms (positive or negative) since beginning this diet?

Appetite

1. How is your appetite?
2. Do you eat three meals a day? If not, how many do you eat?
3. Are you hungry at breakfast or do you usually skip it?
4. After you eat, how long do you stay full?
5. Do you crave any foods (e.g. sugar, salt, caffeine)?
6. How much water do you drink?

What percentage of your meals are home-cooked?

□ 10 □ 20 □ 30 □ 40 □ 50 □ 60 □ 70 □ 80 □ 90 □ 100

Is there anything else I should know about your current diet, daily food intake, history or relationship to food?

**Intestinal Status**

Bowel Movement Frequency

□ 1–3 times per day

□ more than 3 times per day

□ not regularly every day

Bowel Movement Consistency

□ soft & well formed

□ often float

□ difficult to pass

□ diarrhoea

□ thin, long or narrow

□ small and hard

□ loose but not watery

□ alternating between hard and loose

Bowel Movement Colour

□ medium brown

□ very dark or black

□ greenish

□ blood is visible

□ variable

□ yellow, light brown

□ chalky coloured

□ greasy, shiny

Do you experience intestinal gas, bloating, belching or flatulence? If so, please explain if it is excessive, occasional, odorous, etc:

Have you ever had food poisoning? If yes, please describe in detail, including:

1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it

How often do you urinate and what colour is your urine?

Are there any problems – pain, difficulty starting or stopping etc?

**Medical Status**

Please check any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

□ Cancer

□ Heart Disease

□ Hepatitis

□ Venereal Disease

□ Diabetes

□ High Blood Pressure

□ High Cholesterol

□ Kidney Disease

□ Thyroid Disease

□ Depression

□ Asthma

□ Allergies

□ Anaemia

□ Chronic Yeast Infections

□ Other

**Medications**

Indicate with a checkmark or circle any medications you’re currently taking or have taken in the last 6 months:

□ Antacids

□ Antibiotics

□ Anticonvulsants

□ Antidepressants

□ Antifungals

□ Aspirin/Ibuprofen

□ Asthma inhalers

□ Beta blockers

□ Chemotherapy

□ Cortisone

□ Diabetic medications

□ Diuretics

□ Estrogen/Progesterone

□ Heart medications

□ High blood pressure

□ Hormone Therapy

□ Laxatives

□ Insulin

□ Oral/implant contraceptives

□ Radiation exposure

□ Recreational drugs

□ Relaxants/Sleeping pills

□ Thyroid medication

□ Tylenol/acetaminophen

□ Ulcer medications

□ Other medications and dosages (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Hazards**

Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminium)?

Do odours affect you?

Are you or have you been exposed to second-hand smoke?

Do you have mercury amalgam fillings?

**Lifestyle, Exercise, Stress and Mood**

Do you exercise? How many times per week do you exercise and what do you do?

Do you enjoy exercise?

Have you changed jobs (within last 2 months/ within last 6 months/ within last 12 months)?

Have you Separated/ Divorced (within last 6 months/ within last year/ within last 2 years)?

Do you work over 60 hours/week (Always/ Usually/ Occasionally, Never)?

Have you had periods of eating junk food, binge eating or dieting?

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

How do you handle stress? How would you rate your current level of stress? How would you rate your general response to stress?

How are your emotions generally (i.e. balanced, fluctuating, depressed, anxious etc)?

Are there specific emotions you experience more often?

Is there a time in the month when you notice certain emotions? Do you know if they correlate to your cycle? (For instance, do you feel more anxious or depressed a few days before your period?)

What area in your life do you struggle with most?

Are you a perfectionist in any (or all) areas of your life?

Do you feel anxious or overwhelmed? How often?

What’s weighing you down?

How does stress manifest itself physically – do you feel pain anywhere because of it (back, neck, shoulders for example)?

**General Energy**

What is your energy like through out a typical day? Include how your energy levels are upon waking, just after eating and several hours after eating, especially any notable peaks or falls during the day.

Do you feel tired 1-2 hours after meals?

Do you have energy crashes mid-morning or mid-afternoon? Or at any other time of day?

If you experience energy crashes, what do you do to help them (eg coffee, sugar, rest, exercise)?

**Sleep History**

Are you satisfied with your sleep?

What time do you usually go to bed, fall asleep and wake up?

Are you tired when it is time to go to bed?

Do you fall asleep in less than 30 minutes?

Do you sleep between 6 and 8 hours per night?

Do you sleep a full night without waking? If you do wake up, what time is it? Do you fall back to sleep easily?

Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

Do you have night sweats?

Do you wake to go to the toilet in the night?

Do you stay awake all day without dozing or napping?

**Menstrual Cycle, Fertility, Gynaecology**

How long is/was your menstrual cycle (from day one of your period to the day before your next period)?

How long is/was your period (actual flow, not including spotting)?

How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

Do you experience physical symptoms leading up to and during your period (nausea, PMS, breast tenderness, spotting, diarrhoea, water retention, bloating etc)?

Do you experience emotional symptoms leading up to and during your period (anxiety, depression, anger, moodiness, snappiness, short temper etc)?

What is the colour and consistency of your period? (ie it begins dark or light, tapers off/ ends suddenly, any clotting etc)

Is there any pain, and if so say more about it and how your manage it – eg with pressure, warmth, pain killers etc.

How much does pain or heavy bleeding or other menstrual issue affect your life?

Have you experienced any yeast infections, bacterial infections or urinary tract infections? Are they regular?

Have you taken/do you still take birth control pills: If so, please list length of time and type.

Have you had any problems with conception or pregnancy?

Please share your menstrual and fertility history – any surgery, births, IVF, assisted conception etc

Have you had to take time off work or studies in the last year because of your health issues? How much?

What will your life look like once you address your specific health issues?

What do you see when you visualise your reproductive system?

Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

**Sexual History (answer only what you are comfortable sharing)**

What is your sex drive like? Has it changed recently? Would you like it to be different?

Do you have any concerns or issues with your sexual functioning that you’d like to share here (pain with intercourse, dryness, libido issues)?

How many partners have you had in the past year?

**Mental Health Status**

How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

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

**Other**

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

Who in you family or on your health care team will be most supportive of you making dietary change?

Who gives you support in your life?

Please describe any other information you think would be useful in helping to address your health concern(s):

**Terms**

I understand that my details are to be kept confidential.

I declare that to the best of my knowledge the information I have given is correct. I consent to the practitioner contacting my GP if deemed necessary.

Name:

Signed:

Date: