



## WOMEN'S HEALTH HISTORY

Please write or print clearly. All of your information will remain confidential between you and Stephanie.

### Personal Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_

Current weight: \_\_\_\_\_ Six months ago: \_\_\_\_\_ One year ago: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

### Social Information

Where do you currently live? \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Children: \_\_\_\_\_ Pets: \_\_\_\_\_

### General Health

Please list your main health concerns: \_\_\_\_\_

Other concerns and/or goals? \_\_\_\_\_

At what point in your life did you feel best? \_\_\_\_\_

Any pain, stiffness or swelling? \_\_\_\_\_

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Any serious illnesses, hospitalizations, or injuries? \_\_\_\_\_

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What blood type are you? \_\_\_\_\_

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Do you take any supplements or medications? Please list: \_\_\_\_\_

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What role do sports and exercise play in your life? \_\_\_\_\_

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On average, how many hours do you sleep each night? \_\_\_\_\_ Do you have trouble falling sleep? \_\_\_\_\_

Do you wake up throughout the night? \_\_\_\_\_

### Digestive Health

Do you have a bowel movement daily? \_\_\_\_\_

Do you experience constipation regularly? \_\_\_\_\_

Do you experience diarrhea regularly? \_\_\_\_\_

Do you get gassy and bloated frequently? \_\_\_\_\_

Do you get heartburn or acid reflex? \_\_\_\_\_

Do you have food sensitives or allergies? If so, to what foods? \_\_\_\_\_

### Women's Health

Are your periods regular? \_\_\_\_\_ How many days is your flow? \_\_\_\_\_ How frequent? \_\_\_\_\_

Painful or symptomatic? Please explain: \_\_\_\_\_

Birth control history: \_\_\_\_\_

Reached or approaching menopause? \_\_\_\_\_

Do you experience yeast infections or urinary tract infections? \_\_\_\_\_



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### Food Information

What is your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is there anything special about your diet I should know? \_\_\_\_\_

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

Do you crave sugar, salt, coffee or alcohol? \_\_\_\_\_

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

### Additional Comments

The most important thing you think you should do to improve your health is: \_\_\_\_\_

\_\_\_\_\_

Anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### Miscellaneous

How did you discover my practice? \_\_\_\_\_

Can I add you to my e-mail list (only used to distribute blog posts, recipes, etc.)? \_\_\_\_\_



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## DISCLOSURE AND WAIVER OF LIABILITY AGREEMENT

***I, the undersigned ("Client"), acknowledge that I have read and understand the contents of this liability agreement.***

1. Stephanie Rome is a nutrition consultant and does *not* function as a physician, diagnose or treat disease, nor do her services replace the necessary services of a licensed physician.
2. Stephanie Rome makes no representations, claims, or guarantees regarding the efficacy of her recommendations. The recommendations are based upon a combination of her nutrition and health coaching education and knowledge of natural health literature. A nutrition consultation as provided by Stephanie Rome does not constitute a medical service or health care treatment.
3. I understand that the nature of the recommended treatments for my care will be explained to me and that I will have the opportunity to ask questions of those involved in my care. I am not being forced to accept treatment.
4. Individualized recommendations are offered and applied as an educational and informative consultation. Any action taken as a result of the consultation is done at the sole discretion and risk of Client. Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for health condition(s). For example, in the case of children you are advised to seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc.
5. Client's signature verifies that Client has not been told to discontinue treatments with any other medical specialists or other health care providers. Client's signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.
6. Financial Policy: Patients are fully responsible for all professional services received. Client is not contracted with insurance companies and does not bill for services. I, the undersigned, understand that I am responsible for all charges.

By signing below, you agree to comply with the above policies and acknowledge that you understand all terms, verbiage (language) and concepts herein. Furthermore, Client agrees not to hold Stephanie Rome liable for any costs or damages related to the services provided other than for willful misconduct or gross negligence.

I understand this consent agreement and have executed it freely and willingly.

Client Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

