



Mom's Confidential Health History
Nutritional and Wellness Assessment for Parenthood

Name: _____

Address: _____

Email: _____ Home Phone: _____ Cell: _____

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

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

Were you content with your pre-pregnancy weight? _____ If not, what was your ideal weight? _____

Relationship status: _____

Partner's name (if applicable): _____ Expected due date: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Do you plan to return to work after the birth of your child? _____

How is the health of your mother? _____

How is the health of your father? _____

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

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any serious illnesses/hospitalizations/injuries? _____

Any pain, stiffness or swelling? _____

Were your periods regular? _____ How many days was your flow? _____ How frequent? _____

Birth control history: _____

Do you experience yeast or urinary tract infections? Please explain: _____

Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

Please list any supplements or medications you take: _____

Please list any therapies or healers with which you are involved: _____

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

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

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

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

From where do you get the rest? _____

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

What are some of the areas of your health and happiness where you feel you need more support? _____

What challenges are you facing in these areas? _____

What are your greatest concerns about pregnancy and parenthood? _____

How would your life and the life of your family be better if you made positive changes to your wellness? _____

Signature _____ Date _____

Please return completed form via fax to 917-210-4062 or via email to lizandstevedooley@gmail.com