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Children's Health History

Please write or print clearly. All information listed will remain confidential between child, parent and Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Email or parents' email: _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Birthdate: _____ Place of Birth: _____

Height: _____ Weight: _____ Grade: _____

Why did you come for this health history? _____

SOCIAL INFORMATION

Do you enjoy school? Please explain: _____

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

Who is your best friend? _____

_____

What do you do for fun? _____

_____

What is your favorite sport or activity? _____

_____

What are fun things you do with family? _____

_____

What are your favorite things to do when you are alone? _____

_____

What chores do you do around the house? _____

_____

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HEALTH INFORMATION

When is bedtime? _____ When do you wake up? _____

Do you ever wake up at night? _____ Do you ever have nightmares? _____

How is your sleep (i.e., continuous, restful, restless)? _____

Do you get bellyaches? _____ Do you get headaches or earaches? _____

Is it hard to see or read? _____ Do you get itchy? _____

MEDICAL INFORMATION

Do you have allergies or sensitivities? _____

Does anything else hurt? _____

FOOD INFORMATION

What do you eat for breakfast? _____

What do you eat for lunch? _____

What do you eat for dinner? _____

What do you eat for snacks? _____

What do you drink? _____

What foods do you wish you could eat more often? _____

What food do you wish you never had to eat again? _____

What do you want to learn about your body and about food? _____

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Children's Health History

ADDITIONAL INFORMATION

Do you have anything else you would like to share? _____

Toxicity QUESTIONNAIRE

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The Toxicity Questionnaire is a short self-assessment that will help you determine how toxic your body is now, based on the symptoms or conditions you're experiencing. This is your toxicity score "base case."

You may find it helpful to take this questionnaire again every 1-3 months to determine what (if anything) has changed. This comparison will give you valuable information about how your body is reacting to changes in your diet and lifestyle over time.

Respond "yes" or "no" to each question (keep in mind: "maybe" counts as "yes") based on your experience for the past 60 days.

☐ Sugar cravings?
☐ Hunger that's difficult to satisfy?
☐ Low or inconsistent energy?
☐ Fatigue, especially after exercise?
☐ Constipation?
☐ Difficulty sleeping restoratively?
☐ Caffeine addiction?
☐ Bloating or gas?
☐ Reflux or heartburn?
☐ Irritable bowel?
☐ Difficulty losing weight?
☐ Binge eating or drinking?
☐ Fluid retention?
☐ Stuffy or runny nose, itchy nose or eyes?
☐ Chest congestion?
☐ Asthma or wheezing?
☐ Migraines or headaches?
☐ Ringing in ears?
☐ Depression?
☐ Anxiety?
☐ Mood swings?
☐ Irritation?
☐ Brain fog or difficulty with concentration?
☐ Distractibility?
☐ Skin problems, such as acne, rosacea, eczema, or rashes?
☐ Joint problems or pain?
☐ Muscle aches?

Total score _____ Today's date _____

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