Susannah JOHNSON HOLISTIC NUTRITION

Date: _____

Children's Confidential Health History, Intake, and Evaluation

Please print clearly.

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone: _____Parent's Email:_____

Age:_____Birthday: _____Place of Birth: _____

Height: _____Weight: _____ Grade:_____

Why did you come for a health history?

_____

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?_____

_____

Susannah JOHNSON HOLISTIC NUTRITION

When is bedtime?_____When do you wake up?_____

Do you ever wake up at night?

_____

Do you ever have nightmares?

_____

Do you get bellyaches?

_____

Do you get headaches or earaches?

_____

Is it hard to see or read?

_____

Do you get itchy?

_____

Do you have allergies or sensitivities?

_____

Does anything else hurt?

_____

What do you eat for breakfast?

_____

Susannah
JOHNSON
HOLISTIC NUTRITION

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 foods do you wish you never had to eat again?

_____

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

_____

Anything else you want to say?