Fit to You, LLC
Children's Health History Form

Please write or print clearly.

General Information

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone—Work: _____ Home: _____ Cell: _____

Email address: _____ Date of Birth: _____ Place of birth: _____

Age: _____ Height: _____ Current weight: _____ Grade: _____

Health History

Please list your child's main health concerns in the order of importance: _____

_____

Do these health concerns interfere with (check all that apply):

□ school □ sleep □ daily routine □ other ___

Are the symptoms getting progressively worse? □ Yes □ No

Has there been any medical diagnosis of your child's issues? □ Yes □ No If yes, list the doctor's name and the diagnosis.

_____

How have you tried to take care of this problem in the past? Circle all that apply.

Medications ● Emergency room ● Surgery ● Routine medical ● Exercise ● Supplements

Chiropractic care ● Naturopathic care ● Acupuncture ● Nutrition ● Personal trainer ● Other: _____

How did the previous method(s)? _____

Why do think this is the case? _____

What do you desire most to get from working with us? _____

Please list any medications your child currently takes and for what conditions:

_____

_____

Please list any natural supplements you child currently takes and for what conditions:

_____

_____

Please list any other concerns and/or goals: _____

_____

_____

Please list any serious illnesses/hospitalizations/injuries? _____

_____

How is the health of the child's mother? _____

How is the health of the child's father? _____

Any other family history we should know about? _____

What is the child's ancestry? _____ What is the child's blood type? _____

Does the child sleep well? _____ How many hours? _____ Do they wake up at night? _____

Why? _____

Emotional Health/Stress

How stressful is your child's life on a scale of 1 to 10, 10 being the most stressful? _____

Has your child ever been diagnosed with any of the following?

□ Depression □ Anxiety □ Bipolar disorder □ ADD/ADHD □ OCD □ Autism □ Other: _____

Are they taking an anti-depressant or other psychiatric medicine? □ Yes □ No

If yes, which medication(s)? _____

Digestive Symptoms/Food Patterns

Does your child have any of the following currently or in the past (circle all that apply)?

Constipation ● Diarrhea ● IBS ● Gas ● Bloating ● Heart burn ● Crohn's Disease ● Ulcerative colitis

Diverticulosis ● Celiac Disease/gluten sensitivity ● Food allergies ● Food sensitivities

Leaky gut syndrome ●Lactose intolerance ● Gallstones

Is the child on a special diet (Indicate what type of diet.)? □ Yes □ No

□ Ovo-lacto vegetarian □ Vegetarian □ Vegan □ Dairy restricted □ Gluten Free □ Diabetic

□ Other (Please describe) _____

Is there anything else about your child's diet that we should know? _____

Does your child have any allergies or sensitivities? Please explain: _____

_____

Does your child have symptoms <u>immediately</u> after eating (belching, bloating, sneezing, hives, etc.)?

□ Yes □ No

If yes, are these symptoms associated with any particular food or supplement(s)? □ Yes □ No

Please name the food or supplement and symptom(s). Example: Milk—gas and diarrhea.

_____

_____

Does your child appear to have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? □ Yes □ No

Are there certain foods that your child strongly dislikes? □ Yes □ No

If yes, which foods? _____

Describe the frequency of your child's bowel movements (circle the answer that applies).

More than 3X/day ● 1 to 3X/day ● 4 to 6X/week ● 2 to 3X/week ● 1 or fewer X/week

Describe the consistency of your child's bowel movements (circle the answer(s) that applies).

Soft and well-formed ● Often float ● Difficult to pass ● Diarrhea ● Thin, long or narrow ● Small and hard

Loose but not watery ● Alternating between hard and loose/watery

Describe the color of your child's bowel movements (circle the answer that applies).

Medium brown consistently ● Very dark or black ● Greenish color ● Blood is visible ● Varies a lot

Dark brown consistently ● Yellow, light brown ● Greasy, shiny appearance

Does your child have intestinal gas? □ Yes □ No If yes, please describe by circling the appropriate answers.

Daily ● Occasionally ● Excessive ● Present with pain ● Foul smelling ● Little odor

Does your child eat breakfast? □ Yes □ No If so, what is a typically breakfast?

_____

What does your child typically eat for lunch?

_____

What does your child typically eat for dinner?

_____

What types of snacks does your child typically eat?_____ _____

What does your child typically drink? _____

The healthiest three foods my child eats during the week are

_____ _____ _____.

The worst three foods my child eats during the week are

_____ _____ _____.

What percentage of your child's food is home cooked? _____

Where is the rest from? _____

Additional Questions

Was the child breast fed? □ Yes □ No If yes, for how long? _____

Was the child vaccinated? □ Yes □ No

Has the child ever been exposed to second hand smoke regularly? □ Yes □ No

Do the child's symptoms worsen at certain times of the year? If yes, when? _____

Has the child, to your knowledge, been exposed to toxic metals? □ Yes □ No

If yes, which one(s)? Lead ● Arsenic ● Aluminum ● Cadmium ● Mercury

Do odors affect your child? □ Yes □ No If yes, which ones?

_____

Questions to Answer with Your Child

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 you do around the house? _____

_____

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? _____

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

_____

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

_____

Is there anything else you would like to share?

_____

_____

_____

_____

_____

_____