Children's Health History

Name: _____

Address: _____

Telephone: _____ E-mail or parents' email: _____

Age: _____ Birthday: _____ Place of Birth: _____

Height: _____ Weight: _____ Grade: _____

Why did you come for this 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? _____

_____

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?

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?

Anything else you want to say?