Reednutrition

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Pediatric Health History Questionnaire

Please fax, mail or email this and all other relevant reports/forms to be received at least 1 business day prior to your first session.

Child's Name: _____ Date: _____

Address: _____ Child's Sex: _____ Child's Age: _____

City: _____ Zip: _____ Child's DOB: _____

Parent's Name: _____ Child's Height _____ Child's Weight: _____

Home phone _____ Business phone: _____ Email: _____

Primary care physician (name & phone): _____

Referred by: _____ Insurance: _____

Current Health & Lifestyle Issues

1. Briefly describe your goals and expectations for your child's nutritional therapy:

_____

_____

_____

2. Please outline any health issues or symptoms your child has in order of priority, even if you feel they are unrelated to nutrition:

Issue/Symptom	Onset	Frequency	Severity

3. What diagnosis or explanations have been given to date:

_____

_____

_____

4. Does your child currently take any medications, vitamins, herbs, or nutritional supplements? Please list:

Name of med/supp/vitamin	Type	Brand	Dosage

5. Who lives in your home?

Name	Age	Relationship	Occupation

6. Do any pets live with you? Please list: _____

_____

_____

7. Does your child attend school, day care, or activities outside the home?

_____

_____

_____

_____

8. Is your child under stress due to schoolwork, activities, health or family issues?

_____

_____

9. Please describe your child's energy level on a scale of one to five: 1 2 3 4 5

10. How much exercise does your child get?

_____

_____

11. How much sleep does your child get? Does he/she sleep well?

_____

_____

12. Is there anything special about your child's diet I should know about?

_____

_____

13. Does your child have cravings for any particular food?

_____

_____

14. Is your child allergic to or hypersensitive to any foods? Or, are there foods you child has had to avoid because they cause symptoms such as flatulence, constipation, diarrhea, indigestion, stomach upset?

_____

_____

Health History

16. OPERATIONS: Type, when, comments:

_____

_____

_____

17. ILLNESSES: Type, when, comments:

18. MEDICATIONS: How many times and at what ages has your child taken:

	Birth to age 1	Ages 2–5	Ages 6–13	Over age 13
Antibiotics:				
Antihistamines:				
Steroids:				
Aspirin:				
Laxatives:				
Others:				

19. Which immunizations has your child had?

20. Please list all major life events (losses, births, deaths, moves, changes, etc.).

21. Has your child travelled outside the US? When?

22. **For girls only:** Age at start of menstrual period. Are preiods regular? How frequent? Any cramping or other symptoms?.

23. Has your child ever had psychotherapy or counseling? When? What kind?

24. Please give a brief description of your child's family history, e.g. any health problems affecting mother, father, siblings, grandparents:

If you have any recent blood work or medical records pertaining to your current condition(s), please attach these to this questionnaire.