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CHILD'S PERSONAL HEALTH AND LIFESTYLE INTAKE

Name of Child_____ Home Phone_____

Address_____ Parent's Work_____

City_____ Cell_____

State_____ Zip_____ Fax_____

Parent Email_____

Mother's Name_____

Occupation_____

Father's Name_____

Occupation_____

Parents are: Married_____ Divorced_____ Separated_____ Single_____

With whom does the child live?_____

Child's DOB_____ Age_____ Male_____ Female_____

Birthplace_____

Hospital Birth_____ Home Birth_____

Child's School_____

Emergency Contact_____

Relationship_____Phone_____

Physician's Name and Location_____

When was your child's last visit to the doctor_____

What was the reason?_____

Is your child under the care of a medical specialist?_____

If yes, please explain_____

List all hospitalizations and surgeries:

DATE	HOSPITALIZATION	SURGERY	REASON

What is your child's most important health concern?_____

_____

_____

_____

_____

_____

_____

BIRTH HISTORY
Any problems during pregnancy?_____

_____

Was mom on any medications during pregnancy or during breast feeding?_____

Please list_____

Were cigarettes, alcohol, drugs used during pregnancy?_____

How was the child delivered?_____

Any complications during or after delivery?_____

DEVELOPMENT HISTORY
Was/is the child breast or bottle fed_____ For how long?_____

Have you ever been concerned about your child?_____

Slow development (sitting, walking, talking)_____

Speech_____

School difficulties (learning, attention)_____

How is your child's energy level?_____

Lowest time of day?_____ Highest time of day?_____

Has/is your child currently working with Holistic Practitioners?_____

For what condition?_____

_____

List Current Herbal Remedies, Vitamins and Nutritional Supplements

PRODUCT	LENGTH OF TIME	DOSAGE

FAMILY HISTORY

Please check if your child or any family member has had the following conditions:

CONDITION	CHILD	OTHER FAMILY MEMBER
alcoholism		
allergies		
arthritis		
asthma		
bleeding disorders		
cancer		
depression		
diabetes		
drug addiction		
eczema		
epilepsy/seizures		
GI disorder		
gum disease		
hay fever		
heart murmur		
high blood pressure		
high cholesterol		
genetic disorder		
liver disease		
mental illness		
musculoskeletal disorder		
neurological disorder		
sudden death		
stroke		
thyroid condition		
tuberculosis		

CONDITION	CHILD	OTHER FAMILY MEMBER
ulcer		
urinary disorder		
vascular disorder		

What are your goals for your child's health?

1. _____

2. _____

3. _____

What symptoms or problems are your child presently experiencing?

1. _____

2. _____

3. _____

4. _____

5. _____

EMOTIONAL OBSERVATIONS

How does your child behave when he/she is very upset?

_____

_____

_____

Does your child sleep well?_____

Wake rested?_____

Sleeps for how many hours?_____

Naps?_____

Enjoy school?_____

Spend time outside?_____

What are your child's main interests and hobbies?_____

_____

_____

_____

_____

Additional Comments

_____

_____

_____

_____

_____