Children / Teen Wellness & Nutrition Health History

Please write or print clearly. All information listed will remain confidential between child, parent, and the Doctor.

PERSONAL INFORMATION

First Name: ______________________________

Last Name: ______________________________

Phone: ____________________ Email or parents' email: ____________________

Age: ________ Birthdate: ____________ Place of Birth: ____________

Height: ____________ Weight: ____________ Grade: ____________

Why did you come for this health history? ______________________________

SOCIAL INFORMATION

Do you enjoy school? Please explain: ______________________________

Do you have a large or small group of friends? ______________________________

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? ______________________________

____

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HEALTH INFORMATION

Please list your main health concerns: ________________

____

Other concerns? ________________

Any serious illnesses/hospitalizations/injuries? ________________

____

How is/was the health of your mother? ________________

How is/was the health of your father? ________________

Where do your parents and grandparents come from? ________________

How is your sleep? ________ How many hours? ________ Do you wake up at night? ________

Why? ________________

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? ________

FEMALE TEEN HEALTH

Are your periods regular? ________ How many days is your flow? ____ How frequent? ________

Painful or symptomatic? Please explain: ________________

What is your birth control history? ________________

Do you experience yeast infections or urinary tract infections? Please explain: ________________

MEDICAL INFORMATION

Are you concerned with body image? Please explain: ________________

____

Do you take any supplements or medications? Please list: ________________

Do you have any healers, helpers, therapies, or pets? Please list: ________________

____

MEDICAL INFORMATION (continued)

What role does exercise, sports, and activities play in your life? ______________________

____

Do you have allergies or sensitivities? ______________________

Does anything else hurt? ______________________

____

FOOD INFORMATION

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? ______________________

ADDITIONAL INFORMATION

Do you have anything else you would like to share? ____

____

____