BLU Synergy
WHOLISTICS
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Child Health History

Please answer all applicable questions to the best of your knowledge. We look forward to working with you.

Client Name:_____ Age:_____ Date of Birth:_____

Parent/Legal Guardian's Name: _____ Best Contact Number: (___)_____

School:_____Favorite Things To Do:_____

_____

_____

Favorite Subject: _____ Grade Level:___ ❑ Solid A ❑ A to B ❑ B to C ❑ C and Below

Favorite Classes/Things To Learn About:_____

Favorite Extracurricular Activities:_____

How easily does s(he) make friends? ❑ Very Easily ❑ Pretty Good ❑ Not Very Well ❑ I'm Worried

Insurance Company:_____ Policy:_____ Group #:_____

Name of Insured: _____ Relation to Insured:_____

Social Security Number:_____

Person to call in case of Emergency:_____ Relationship:_____

Emergency Contact Phone Number:___(___)_____

Regular Physician:_____ Phone Number: (___)_____

How Did You Hear About Us? ❑ Referral ❑ Web Search ❑ Email ❑ Facebook ❑ Advertisement ❑ Event

Other - _____

CHILD'S CURRENT HEALTH PICTURE

How Happy Do You Think Your Child Is: _____ (1 to 10) How Happy Does Your Child Say They Are: _____

Average Number of Bowel Movements per Day? _____ Number of Days Each Week without a BM? _____

What are your main health concerns/reasons for your visit? (Please List in Order of Importance)

1. _____ Date First Noticed or Diagnosed: _____

2. _____ Date First Noticed or Diagnosed: _____

3. _____ Date First Noticed or Diagnosed: _____

Please list any Additional Questions or Expectations of the appointment today.

_____

_____

_____

The general state of your child's health is (please circle one): ❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

Is your child currently seeing (a) medical specialist (s)? ❑ Y ❑ N If yes, for what reason? _____

_____

When was the last time your child had blood work or other lab testing performed?(month/year):_____

_____

What type of testing was performed?:_____

Is this your first time working with a Holistic Nutritionist? ❑ Y ❑ N

Family History of Child

	Father	Mother	Siblings	Grandparents
Age if living	_____	_____	_____	_____
Age when died	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____
Cancer (any type)	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
High Blood Pressure	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Heart Attack/Stroke	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Heart Disease	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Asthma/Allergies	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Mental illness	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Drug or Alcohol Addiction	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Auto-immune disease	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Diabetes Mellitus	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Osteoporosis	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N

List any other pertinent family information in the space below:

_____

_____

_____

_____

_____

4 Considerations – Scar Tissue

List All Surgeries and Reasons for Hospitalizations (Include any cosmetic procedures):

1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

5. _____ Date: _____ 6. _____ Date: _____

List All Accidents, Injuries, or Physical Traumas:

1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

5. _____ Date: _____ 6. _____ Date: _____

Please Note When and Why Your Child Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

4 Considerations – Acidic pH

Please Mark Any of the Following You Feel Apply to Your Child:

❑ dark circles under the eyes ❑ acne ❑ eczema ❑ history of asthma/sinusitis ❑ history of hernias
❑ history of irritable or inflammatory bowel ❑ history of acid reflux ❑ history of migraines
❑ history of ear itching/infections ❑ fatigue 2+ hours after eating ❑ itchy eyes ❑ nosebleeds
❑ sore throat/stiff neck

Please List All Sensitivities/Allergies/Reactions:

Drugs: _____

Foods: _____

Environmental: _____

❑ red eyes ❑ sensitive skin ❑ myxedema ❑ zinc spots on nails ❑ brittle nails/hair ❑ multiple broken bones
❑ clear urine ❑ arthritis ❑ easy bruising ❑ slow reflexes/recall ❑ cavities ❑ high blood pressure
❑ low blood pressure ❑ heart palpitations ❑ kidney stones
❑ constipation ❑ clay colored stools ❑ diarrhea ❑ nausea ❑ vomiting ❑ acid reflux ❑ hemorrhoids
❑ hernias ❑ flatulence ❑ rectal bleeding ❑ rectal itching ❑ history of ulcers ❑ mucus in stools
❑ alternating diarrhea & constipation ❑ undigested food in stools

List All Travel Outside of the US Over Last 5 Year? _____

_____

Have your child consumed any untreated river water while hiking or camping? ❑Y ❑N

How many rounds of antibiotics has your child had within the last year? _____ 5 years? _____ Lifetime? _____

List Yes, No, or Past regarding use of the following:

Antacids:	❑Y ❑N ❑P	Laxatives:	❑Y ❑N ❑P
Analgesics:	❑Y ❑N ❑P	Steroids:	❑Y ❑N ❑P
Recreational drugs:	❑Y ❑N ❑P	Any drug treatment:	❑Y ❑N ❑P
Cigarettes:	❑Y ❑N ❑P	Packs per day:_____	
Marijuana:	❑Y ❑N ❑	Days per week:_____	
Alcohol:	❑Y ❑N ❑P	Days per week:_____	
Coffee:	❑Y ❑N ❑P	Cups per day:_____	
Soda Pop:	❑Y ❑N ❑P	Ounces per day:_____	

Did your child have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	❑D ❑I ❑N	Diphtheria:	❑D ❑I ❑N
Mumps:	❑D ❑I ❑N	Tetanus:	❑D ❑I ❑N
Rubella:	❑D ❑I ❑N	Whooping Cough:	❑D ❑I ❑N
Chickenpox:	❑D ❑I ❑N	Hemophilus (Hib):	❑D ❑I ❑N
German Measles:	❑D ❑I ❑N	Hepatitis B:	❑D ❑I ❑N

Any vaccination reactions: _____

Medications: Please give full name, dosage, and length of time that your child has been taking medication

Pharmaceuticals	Dose	When/ How often

Supplements/Herbs	Dose	When/ How often

Did your child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____

Has your child lived where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____

_____

Have your child ever experienced shortness of breath, memory fog, fainting, or any peculiar symptoms after installing new carpet, paint, furnishings, or any other home refurbishing?:_____

_____

Is your particularly sensitive to perfumes, gasoline, or other vapors?:_____

Do you use pesticides, herbicides, other chemicals around your home?_____

How many amalgam 'silver' filings does your child have? _____

Perspiration has Odor: ❑ Y ❑ N

4 Considerations – Emotional Charge

Please Mark Any of the Following You Feel Apply to Your Child:

❑ unworthy ❑ resistant to change ❑ accepting of defeat ❑ busy as escape ❑ excessive concentration

❑ mental chatter ❑ easily overwhelmed ❑ grieving ❑ keeping it inside ❑ can't let go ❑ lack of trust

❑ afraid/worried/anxious ❑ angry ❑ indecisive ❑ frustrated/impatient ❑ complaining ❑ timid ❑ alone

❑ isolated ❑ neglected ❑ guilt ❑ excessive thought/second guessing self

Has your child ever been witness to or subjected to acts of physical violence, abuse or emotional trauma? ❑ Y ❑ N

If 'yes' please list at what age(s)?_____

Has your child ever been in a serious accident or injured in life-threatening situation? ❑ Y ❑ N

If 'yes' please list at what age(s)?_____

Stress History: Please list the 5 most significant, stressful events/relationships/situations in your child's life.

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____
5. _____ Date_____

How many hours does s(he) sleep each night? _____ How long does it take to get to sleep? _____

Do s(he) sleep through the night uninterrupted? ❑ Y ❑ N Does S(He) Dream? ❑ Y ❑ N

If they wake, what is the time & reason: _____

Nightmares: ❑ Y ❑ N Does s(he) wake feeling refreshed? ❑ Y ❑ N

Grind Teeth: ❑ Y ❑ N Does s(he) Snore? ❑ Y ❑ N

Present Weight:_____ lbs Weight One Year Ago:_____ lbs Ideal Weight:_____ lbs

Maximum weight and when:_____ lbs Minimum Weight and when:_____ lbs

Height: _____ ft _____ in

On average, describe their energy level from 1-10 Waking? ____ Evening? _____ (10 = high, 1 = very low energy)

Regularly Feel Energetic: ❑ Y ❑ N
Regularly Feel Fatigue: ❑ Y ❑ N
If they have fatigue, when is it the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ After Eating
If they have fatigue, can they do what you need to during the day (ie for school/family)? ❑ Y ❑ N

4 Considerations – Biomechanical Misalignment

❑ scoliosis ❑ back pain ❑ shoulder pain ❑ neck pain ❑ sciatica ❑ carpal tunnel syndrome ❑ TMJ syndrome
❑ numbness ❑ tingling ❑ seizures ❑ muscle pain that moves from place to place

How often do they Practice Yoga or some alternate form of therapeutic stretching? ____ Days per Week
How often do they use Cardiovascular Exercise? _____ Days per Week. For How Long? _____ Minutes
How often do they get massaged? _____ Times Per Month

General History

Sexually Active: ❑ Y ❑ N
What Hobbies/Interest Bring You The Most Happiness? _____
_____

Are they working with a professional counselor, psychologist, social worker, pastor, or other therapist? ❑ Y ❑ N
Are they happy with their spiritual practice? ❑ Y ❑ N Active? ❑ Y ❑ N
Do they enjoy school? ❑ Y ❑ N

If Applicable - Female Reproductive Post Puberty:
Do They Know How to Identify Genital Warts on their partner if sexually active? ❑ Y ❑ N

Age periods began:_____ Periods occur every:_____days
Periods last: _____days
Are her periods? ❑ regular (4-6 days) ❑ long ❑ short ❑ none
Menstrual Flow? ❑ regular ❑ heavy ❑ scant
What color is the blood? ❑Light ❑ Medium ❑ Dark Red
Spotting or bleeding in between periods? ❑ Y ❑ N

Has she noticed clots?	❑ Y ❑ N	Food Cravings:	❑ Y ❑ N
Cramping:	❑ Y ❑ N	Pain:	❑ Y ❑ N
PMS:	❑ Y ❑ N	Pelvic Pain:	❑ Y ❑ N

PMS Symptoms where relevant:
❑ Water Retention ❑ Breast Tenderness ❑ Irritability ❑ Headaches ❑ Depression ❑ Mood Swings

_____**I understand that the extent to which my health goals are successful will be determined by the amount of energy, commitment, and dedication I give to support the work I am endeavoring into.**

_____**I accept responsibility for my health.**

