CHILDREN'S HEALTH HISTORY

Please write or print clearly. Your information will remain confidential between you and your Health Coach.

PERSONAL

First Name: _____

Last Name: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Phone: _____ Email (or parents' email): _____

Weight: _____ Grade: _____ Why did you sign up for a Health History? _____

_____

SOCIAL

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 your family? _____

_____

What are your favorite things to do when you are alone? _____

_____

What chores do you do around the house? _____

_____

GENERAL HEALTH

When is your bedtime? _____ When do you wake up? _____

Do you ever wake up at night? _____ Do you ever have nightmares? _____

CHILDREN'S HEALTH HISTORY

GENERAL HEALTH (continued)

Do you get stomachaches? _____ Do you get headaches or earaches? _____

Is it hard to see or read? _____ Do you get itchy? _____

MEDICAL

Do you have allergies or sensitivities? _____

Does anything else hurt? _____

FOOD

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 foods do you wish you never had to eat again? _____

What do you want to learn about your body and about food? _____

ADDITIONAL COMMENTS

Is there anything else you would like to share? _____