Thank you for trusting Restore True Health with your child's care.

This form focuses on health and nutrition-specific information to help guide your child's wellness plan.

PARENT INFORMATION

Parent's Full Name:

Address: **City:** **State:** **Zip code:**

Email:

Phone Number:

CHILD INFORMATION

Full Name:

Sex: **Age:** **Date of birth:**

Height: **Weight:**

PREGNANCY & BIRTH HISTORY

Pregnancy Complications:

Birth Type (vaginal, C-section, assisted):

Birth Weight:

Was your child breastfed? If yes, how long? **If no, what formula was used?**

Any infancy concerns?

Primary Reason you are seeking nutritional support for your child:

What are your top three goals for your child's health?

1.

2.

3.

Current over-the-counter medications, prescription medications, and supplements taking (please include brand names):

How would you describe your child's personality and their likes/dislikes?

Check Box indicating vaccine received and write year received, if possible:

	MMR (Measles, Mumps, Rubella)		**Polio**
	Tdap (tetanus, diptheria, pertussis)		**Influenza (list years taken)**
	HPV (Human papillomavirus)		**Chickenpox (Varicella)**
	Meningococcal		**Covid (please provide # doses & brand taken)**
	Pneumococcal		**Small pox**
	Dengue		**Shingles**
	Hepatitis A		**Rabies**
	Hepatitis B		**Rotavirus**
			Other:

Family medical history (parents & grandparents on both sides):

Personal medical history & any past surgeries:

When was the child's last high fever (above 101.3)? What were the symptoms at the time?

How often does the child experience a common cold? Does the cold resolve on its own or does it go into secondary infections?

Does the child suffer from any skin issues or had skin issues in the past?

Has the child ever suffered from a concussion? If so, how long ago?

Please take your time to pause and reflect when answering the following questions/symptoms below. Every question has a purpose; you DO NOT need to remember every detail. Once the form is received, it will be thoroughly looked through and patterns may be seen. Although there are sections of the body being addressed on the questions below, holistic well-being is not 'sectioned'. All the information given will be integrated into the session to get a more in-depth case history. You may notice some connections as you fill in the form. You may notice symptoms may have started following a medical procedure or an emotional event. This form is meant to help you reflect back on your child's health journey as well as to gather information so the best support can be provided.

Simply circle what symptoms are definitely present. This is a general list of symptoms and depending on the age of your child some symptoms may not apply in general.

IMMUNE HEALTH: frequent colds/flu, herpes/cold sores, ear infections, postnasal drip, cough with mucus, strep throat, throat infections, boils/styes, sinus infections, allergies, slow recovery from illness, poor wound healing, dark areas under eyes, inflamed/bleeding gums, swollen lymph glands, frequent antibiotics, eczema, other:

ENERGY, GROWTH & DEVELOPMENT: fatigue, low stamina/tires easily, difficulty walking or poor coordination, growth concerns, focus concerns, other:

MOOD, BEHAVIOR & NERVOUS SYSTEM: sensitive, easily overwhelmed, worries, trouble relaxing, sleep difficulties, irritable, emotional outbursts, perfectionistic tendencies, other:

SKIN HEALTH: eczema, dry skin, acne, rashes, hives, itching, keratosis pilaris (aka "chicken skin"), other:

DIGESTION & GUT HEALTH: bloating, lower bowel gas several hours after eating, gas in general, burning stomach sensation, constipation, diarrhea, alternating diarrhea/constipation, bad breath, stomach aches/cramping, nausea, reflux, coated tongue, rectal itching, difficulty gaining weight, international travel, burping, food sensitivities, appetite concerns, other:

SLEEP:

Bedtime:

Wake time:

Does your child wake up feeling rested?

Sleep concerns (if any):

BONES & MINERALS: hip and joint pain, dental cavities, tendency towards slouching, brittle/soft nails, any broken bones or tendency towards sprains:

LIFESTYLE & ENVIRONMENT:

Hours of screen time per day _____

exposure to chemicals (ex: household cleaning products, pesticides, paint, salon), mold or water damage in the home, living near power lines, mercury fillings (silver ones), other:

RESPIRATORY SYSTEM: allergies, wheezing, shortness of breath, chest pain, asthma, chronic cough, excessive mucous, cold/flu, skin issues, other:

FILTERING SYSTEM: water retention, fatigue, dizziness, fear, feeling insecure, frequent urination, difficult urination, incomplete emptying of bladder, frequent kidney/bladder infections, painful urination, difficulty starting urination stream, legs nervous at night (involuntary movement), poor memory, lower back pain, other:

What physical activities do they do to move their body and elevate their heart rate and how often?

BOWEL HABITS: straining to pass stool, no desire to pass stool, discomfort passing stool

_____

_____

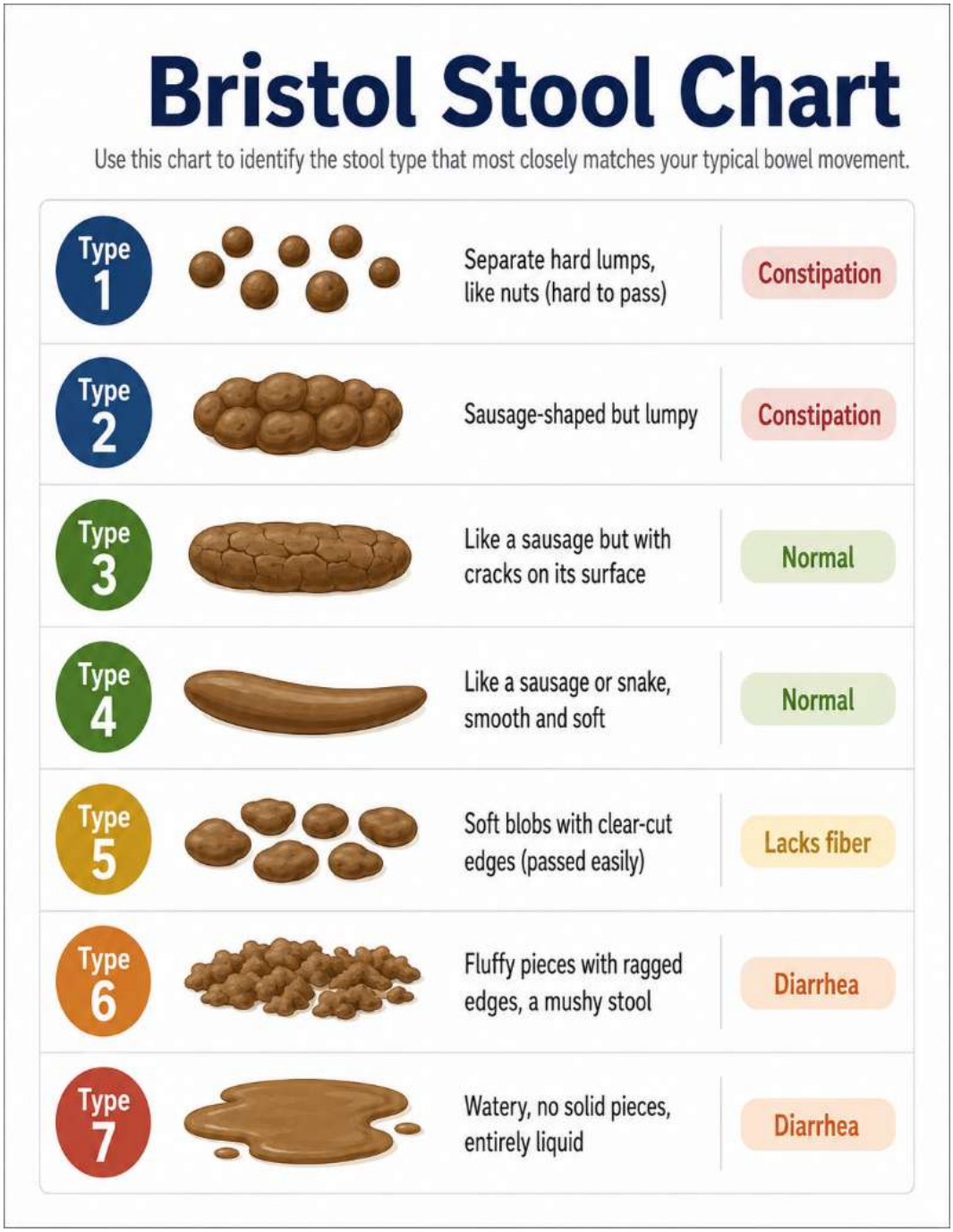
_____

How many bowel movements a day? _____

How often does your child skip a day without a bowel movement? _____

Color of stools: light brown, medium brown, dark brown, yellow/golden, tan, red/bright-red streaks, black, pale/clay-colored, gray, color varies frequently, other:

Using the chart below, indicate which types of stools your child passes: _____



FOOD DIARY

This is very important; please write down all the foods and drinks they consume over an average 2-day period. Include everything they consume from the moment they wake to the moment they fall asleep. If you are able to provide the brands of food items and the amount of fluids in ounces that would be helpful. Thank you!

Day 1:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Day 2:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Are there any foods that would be difficult to remove of their lifestyle?

One serving is roughly the amount that fits in your child's cupped hand.
How many servings of fruit do they eat a day? 0 1-2 3-5 More than 5

How many servings of vegetables do they eat a day? 0 1-2 3-5 More than 5

How much water do they drink a day? Less than 17oz 17-34 oz 34-68 oz More than 68 oz

Is there any additional information you would like to provide?

FORM OF CONSENT TO TREATMENT: I voluntarily request nutritional consultation and wellness coaching from Leanne Wasilewski through Restore True Health. I understand that nutritional consultation is intended to provide education and guidance regarding nutrition, lifestyle, and wellness. These services are not intended to diagnose, treat, cure, or prevent disease and are not a substitute for medical care provided by a licensed healthcare professional. I understand that any nutritional recommendations, supplement suggestions, educational resources, or lifestyle guidance are offered to support overall health and well-being. I acknowledge that I am responsible for the health decisions made on behalf of my child and for discussing any medical concerns with my child's healthcare provider when appropriate. Where appropriate during the final assessment process of the New School of Nutritional Medicine, I understand that my case may be reviewed confidentially with supervising faculty for educational and quality assurance purposes. By signing below, I acknowledge that I have read, understood, and voluntarily consent to receive nutritional consultation and wellness coaching through Restore True Health.

☐ *I acknowledge that I have received and reviewed the Restore True Health Notice of Privacy Practices (HIPAA).*

_____
Parent Signature

_____
Printed Name

_____
Date