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

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? |   |

|  |  |
| --- | --- |
| 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 family? |  |
|  |  |

|  |  |
| --- | --- |
| What are your favorite things to do when you are alone? |  |
|  |  |

|  |  |
| --- | --- |
| What chores do you do around the house? |  |
|  |  |

HEALTH INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| When is bedtime? |  | When do you wake up? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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?  |  |

MEDICAL INFORMATION

|  |  |
| --- | --- |
| 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? |  |
|  |  |
|  |  |
|  |  |