AIIN
HOLISTIC NUTRITION

Child Assessment Form (0-12 yrs)

Child's Name:

Date of Birth: Age: Gender:

Parents/Guardian Name:

Address:

Occupation:

Email address:

Telephone:

Is your child under the care of another healthcare provider? If so, who?

Name:_____

Address: _____

Phone number: _____

Name: _____

Address: _____

Phone number: _____

Main Concerns:

1. _____
2. _____
3. _____
4. _____

Has your child even been hospitalized? Had surgery? Been involved in an accident or experienced trauma?

_____

Please list all medications including vitamins, minerals, natural products, homeopathic remedies and over-the-counter medications you are currently giving to your child including the dosage and reason:

_____

_____

Allergies or Sensitivities?

_____

Has your child been prescribed antibiotics? If yes, for what reason? _____

Has your child been vaccinated? _____ Any adverse reactions? _____

Was your child breastfed? _____ For how long? _____

Formula? _____

Has your child been introduced to solid foods? _____ If yes, is there anything that they cannot tolerate?

_____

Describe your child's personality: _____

What is the emotional environment in the home? _____

Are there any other children in the home? _____ Pets? _____

Does anyone in the home smoke? _____

Prenatal Health & Birth History

What was the health of the mother at conception? Unknown_____ Poor _____ Fair _____

Good _____ Excellent _____

What was the health of the father at conception? Unknown _____ Poor _____ Fair _____

Good _____ Excellent _____

How was the mother's health/diet during pregnancy? Unknown _____ Poor _____ Fair _____

Good _____ Excellent _____

Term length: Full Term _____ Premature _____ (wks) _____ Late _____ (wks) _____

Was the birth vaginal or c-section? _____

Any birth complications? If yes, please explain _____

Do either of the parents have a chronic illness? If yes, please explain.

_____

_____

Is there are family history of chronic illness? If yes, please explain.

_____

_____

Child's Diet

What foods have been introduced to your child?

_____

_____

_____

What are your child's favourite foods?

_____

_____

_____

What foods does your child dislike?

_____

_____

_____

Please provide examples of your child's typical meals with portion sizes and quantities

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Health and Development

How was your child's health during their first year? Unknown_____ Poor _____ Fair _____

Good _____ Excellent _____

Please describe your child's behaviour and temperament.

_____

_____

_____

Please describe your child's sleep patterns.

_____

_____

_____

_____

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Please describe your child's performance at school

_____

_____

_____

What are you child's favourite activities?

_____

_____

_____

Does your child exercise regularly? If so, for how long each day?

_____

_____

How much television/tablet time does your child get per day? _____

Does your child like to read? Or does someone read to your child? How often?

_____

Is your child regularly exposed to toxins or other hazards? (ie. at home, school, outdoors)

_____

_____

Are there any other concerns that you would like to mention that have not been addressed?

_____

_____

_____

_____

_____

The information I have provided is true and complete to the best of my ability.

Signature _____

Date: _____