CHILDRENS KICKSTART CONSULTATION FORM

Please write or print clearly. All of your information will remain confidential between you and the health coach.

Personal Information

Full Name _____ Email _____

Best Phone _____ How often do you check your email? _____

Age _____ Height _____ DOB _____ Place of Birth _____

Current Weight _____ Weight 6 Months Ago _____ Current Grade _____

Why did you want this consultation? _____

_____

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 types of things do you like to do alone? _____

_____

What chores do you do at home? _____

_____

Bedtime? _____ Wake up? _____

Do you wake up at night? _____ Any Nightmares? _____

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

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

Any allergies? _____

Does anything hurt on your body? _____

Birth control history _____

Medical Information

Do you take any supplements or medications? Please list. _____

_____

Are you involved with other healers, helpers or therapies? Please list. _____

_____

Do you have a pediatrician? _____

Diet Information

What foods do you eat the most as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What foods do you dislike most? _____

Do you cook? _____ How often? _____ Where do you get food from? _____

Do you crave sugar, salt, coffee, etc? _____

What do you want to improve most? _____

Who will support you in this journey? _____

Anything else you'd like to share? _____