Essential WELLNESS With Dani Shahan

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: _____ Weight:_____ Date of Birth:_____ Grade:_____

Email: _____

Home Phone: _____Work Phone: _____ Cell:_____

Why did you come 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/activity?_____
What are fun things you do with your family?_____
_____
What are your favorite things to do when you're 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? _____

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Medical Information

Do you have any allergies or sensitivities?_____

Does anything else hurt?_____

Food

What foods do you eat?

Breakfast	Lunch	Dinner	Snacks	Drinks

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 Comments

Is there anything else you would like to share? _____

_____

_____

_____

_____

_____