OCWC Dietary and Lifestyle Counselling

Health History Assessment Form – Children (up to 13 years)

Confidential Patient Information

Name: _____ Date: _____
Address: _____ City: _____ Province: _____ Zip Code: _____
Parent's/Guardian's E-mail: _____ Phone: _____
Height: _____ Age: _____ Sex: Male ◯ Female ◯
Family Physician: _____ Phone: _____
Is your child currently seeing other health practitioners such as a chiropractor, reflexologist, homeopath, naturopath, etc.?
Yes ◯ No ◯ Please list: _____
How did you hear about our services? _____
What is your child's main concern? _____
List current health problems for which your child is being treated:

_____

_____

_____

Does your child get colds and flus often? _____
Does your child have a history of infections? _____
Any recent antibiotic treatment? When and for what?

_____

Has your child ever had Candida (yeast infections)? Other fungal infections?

_____

Does your child have mercury amalgam fillings? How many? Any dental problems?

_____

Is there anything your child has experienced after which you could say his/her health has never been the same since?

_____

Is your child exposed to cigarette smoke or second hand smoke?

_____

What types of therapies have you tried for your child before or currently? Select all that apply:
Diet modification ☐ Live Blood Analysis/Nutritional Counselling ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐
Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐
Other: _____
Has your child had any surgeries? What and when? _____
Name all medications your child is currently using (prescription and/or over-the-counter):

_____

_____

_____

List all laboratory procedures performed (e.g. stool analysis, blood and urine chemistries, hair analysis):

_____

_____

Outcome: _____
Has your child had any accidents? Please explain: _____
How was your child delivered? Natural birth ☐ C-Section ☐
Other: _____
Does your child have any family history of any of the following? Cancer ☐ Heart disease ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐
Other: _____
Select the level of stress your child may be experiencing on a scale of 1 to 10 (1=lowest): 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯
Has your child had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____
How many bowel movements does your child have? _____ p/day _____ p/week
How would you describe your child's stools? Select all that apply:
Loose ☐ Watery ☐ Foul smelling ☐ Firm ☐ Heavy ☐ Hard ☐ Soft ☐ Well-shaped ☐ Floating ☐
Containing: Blood ☐ Mucus ☐ Visible food particles ☐
Colour: Brown ☐ Grey ☐ Pale ☐ Black ☐

Diet & Activity

Is your child on any special diet? Please name: _____
List all nutritional and/or dietary supplements your child is currently using:

How would you describe your child's activity level?
No Exercise (very light) ○ Some Exercise (light) ○ Moderate ○ Athletic (heavy) ○ Elite Athlete (exceptional) ○
Does your child have any food, environmental or drug allergies? Also, list any foods he/she may be sensitive to:

List the foods your child loves:

List the foods your child craves:

List the foods your child dislikes:

List the foods your child eats on a daily basis:

List the foods your child is avoiding for religious reasons:

How often does your child eat bread and/or pasta, and what kind is it?

Does your child drink any of the following and if so how much per day?
Soft drinks: Yes ○ No ○ _____
Fruit juices: Yes ○ No ○ _____
Coffee: Yes ○ No ○ _____
Milk: Yes ○ No ○ _____
Tea: Yes ○ No ○ _____
Water: Yes ○ No ○ _____
What kind of water does your child drink?
Spring ☐ Distilled ☐ Reverse Osmosis ☐ Well ☐ City-Chlorinated ☐
How often does your child eat in restaurants and/or fast foods?

How often does your child eat raw foods (veggies/fruit)?

What are your current health goals for your child?

What are your current dietary goals for your child?

24 Hour Dietary Recall:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Other:

***NOTE**: Please bring with you any other information or test results that may support this consultation.*
Thank you for taking the time to fill out your information to help me assist you and your child best!
Karlien Bester, MASc (Nutr), NNCP