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: __________DOB:__________ Sex: Male o Female o
Family Physician: ______________________________ Phone: ______________________________
Is your child currently seeing other health practitioners such as a chiropractor, reflexologist, homeopath, naturopath, etc.?
Yes o No o 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 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o 10 o
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) o Some Exercise (light) o Moderate o Athletic (heavy) o Elite Athlete (exceptional) o

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 o No o ______________________________

Fruit juices: Yes o No o ______________________________

Coffee: Yes o No o ______________________________

Milk: Yes o No o ______________________________

Tea: Yes o No o ______________________________

Water: Yes o No o ______________________________

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!
Alicia Miller, CHNC