Path to Health

PEDIATRIC LIFE STYLE ASSESSMENT FORM

Name:_____Date:_____
Age:_____ Birthday:_____ School Grade: _____Sex: ____
Please answer each of the following questions. If you require additional space, use the blank Page following the form.

What is your purpose in coming today?
_____
_____
What are your child's main health concerns/complaints?
Please list in order of priority. When did you first notice the symptom?
1._____
2._____
3._____
What triggers these conditions? _____
_____
To what extent does this problem affect their/your daily life?(school, sleep, eating, family life, etc)
_____
Please list, if any, what treatments have been used for this condition(s)._____
Has your child experienced trauma / loss in their life (moving, family, friends) in the last 5 years?
_____
What level of stress do you feel your child is experiencing at this time?

Minimal ☐ Average ☐ Considerable ☐ Unbearable ☐

How does his/her stress manifest?
_____
How does your child cope with stress? What are his/her coping mechanisms?
_____
What activities is your child active in?_____
Does your child need to: lose weight ☐ gain weight ☐ How Much?_____
How many hours does your child spend daily, on average..
Watching TV____ Reading____ In front of the computer _____ Free Play time_____
What are his/her hobbies and interests?_____
How many hours on average does your child sleep daily (include naps)_____ What time does he/she go to sleep?_____ Awaken? _____ Is he/she feel well rested? Yes ☐ No ☐
Does he/she have problems falling asleep at night?_____
Does he/she stay in their bed the whole night?_____

ENVIRONMENTAL FACTORS:
Please check if you use any of the following:

☐ Artificial sweeteners (diet pop, gum, yogurt, juice)
☐ Luncheon Meats
☐ Margarine
☐ Fast Foods
☐ Aluminum cookware
☐ Microwave

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☐ Household Cleaners
☐ Non organic soaps, lotions, shampoos, cosmetics
☐ Smoker in the home
☐ Annual Flu shot

MEDICAL HISTORY:

Has your child ever been diagnosed with an ailment? If so, please list and include date of diagnosis.

_____

Is he/she currently taking medication? Yes ☐ No ☐

List Meds and reasons for them_____

_____

Please list any vitamin, minerals, herbal or homeopathic remedies your child is currently taking including the dosages._____

_____

Does the child have any known allergies or sensitivities to food drugs or environmental?

Does your child have any know learning disabilities?_____

_____

How is your child's performance at school?_____

Mother's Prenatal History

Diet during pregnancy: _____

Supplements and/or medicines taken during pregnancy:_____

Mom's mental/emotional/physical health during pregnancy: Excellent☐ Good☐ Fair☐ Poor☐

Explanation if fair or poor_____

Please check any conditions that applied:

☐ Bleeding ☐ Nausea ☐ Vomiting ☐ Hypertension
☐ Toximia ☐ Anemia ☐ Diabetes ☐ Thyroid Problems
☐ Illnesses ☐ Medications ☐ Alcohol/Drug Use ☐ Cigarettes
☐ Physical or Emotional Trauma

Term

☐ Full term baby ☐ Premature ☐ Late

Weight at birth:_____

Has your child had any of the following illnesses

☐ Frequent colds ☐ Ear infections ☐ Tonsillitis or Strep throat
☐ Pneumonia ☐ Asthma ☐ Cradle Cap
☐ Colic ☐ Chicken Pox ☐ Measles, Mumps, Rubella
☐ Mononucleosis ☐ Whooping cough ☐ Other

Immunizations

☐ Diphtheria ☐ Tetanus ☐ Polio ☐ Hepatitis
☐ Measles, Mumps, Rubella ☐ Small pox ☐ Chicken Pox
☐ Other

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Symptoms
(Mark" C "for current and " P" for past symptoms)

___Hives	___Eczema	___Chronic Rash	___Hair Loss	___Excessive Fatigue
___Bedwetting	___Sore Throats	___ Canker Sores	___Cough	___Heart Murmur
___Cries Easily	___Sleep Issues	___ Nightmares	___Night Sweats	___ Walks in Sleep
___Talks in Sleep	___Bruises Easily	___Dizzy Spells	___Burning Urination	
___Wheezing	___Anemia	___High fevers	___Blood in Urine	
___Stomach Aches	___Constipation (1 or less bowel movements per day)			
___Diarrhea	___Gas	___Change in Appetite	___No appetite	
___Vomiting spells	___Bleeding Gums	___Nosebleeds	___Nervous	
___Sensitive to light	___Bad Breath	___Body Odour	___Motion Sickness	
___Freq. Headaches	___Joint Pains	___Flat Feet	___Hearing Loss	

FAMILY MEDICAL HISTORY: Use " F" for Father, " M" for Mother, " S" for Sibling, " G" for Grandparent "O" for Others.

___ Arthritis	___ Gallbladder Problems	___ Mental Illness
___ Allergies	___ High Blood Pressure	___ Osteoporosis
___ Asthma	___ Heart Disease	___ Ulcers
___ Alcoholism	___ Intestinal Disease	___ Cancer: Type(s)_____
___ Diabetes	___ Kidney Dysfunction	___ Other_____

DIETARY HABITS:

Is your child a Vegan_☐_, Vegetarian _☐_
How often does he/she consume red meat (beef, pork, lamb)? Daily ☐ 3-5X/wk ☐ 1X/wk or less ☐
How does he/she consume dairy products ? Daily ☐ 3-5X/wk ☐ 1X/wk or less ☐
What are his/her favourite foods?_____
How often does he/she have them?_____
What foods does he/she avoid and why?_____
Does your child experience any symptoms after meals? (indigestion, bloating, gas, headache, etc.)
_____
If your child misses a meal does he/she experience any symptoms?(headache, nausea, light-headedness, irritable, etc. Explain._____
_____
How often do you eat at restaurants?_____
Who usually does the grocery shopping and cooking?_____
Does your child eat meals: With Family ☐ On the Run ☐ In front of the TV ☐

How many ½ cup servings of each does your child typically eat in one day:

____Fruit: Fresh ☐ Canned ☐ Dried ☐ ____ Vegetables: Cooked ☐ Raw ☐
____Whole Grains ____ Refined flour (white bread, rice or pasta)
____ Dairy Products: Type_____
Other for example Soy, almond or rice milk_____

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Give an example of your child's typical meals:

Breakfast: _____
_____
Snack:_____
Lunch: _____
_____
Snack:_____
Dinner:_____
_____
_____
Snack:_____
_____

Please indicate how many of cups (8oz) of the following you drink per day:

___Water	___ Milk 1%, 2%	___Milk, Skim
___Fruit Juice	___ Fresh Fruit Juice	___Fresh Vegetable Juice
___Pop	___ Diet Pop	___Kool Aid or similar drinks

CLIENT STATEMENT:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Name of Child:_____

Name of Guardian: _____(Please Print)

Signature: _____Date:_____

Address:_____
_____

Phone: (Home)_____(Business or Mobile)_____

Email:_____

Clear Form Fields Send Form

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