Health History – Healthy Solutions

Child's Name _____ Date: _____

Parent's Name _____

Address_____

City _____ State _____ Zip _____

Parent's Home _____ Work _____ Cell _____

Parent's Email _____

Child's date of Birth _____ Weight _____ Height _____

How did you hear of Healthy Solutions? _____

Reason for consultation and/or goals: _____
_____
_____

Family History of Illness & Disease

Mother: _____
Father: _____
Brothers/Sisters: _____
Grandparents: _____

Disease(s)/Illness(es) your child has been diagnosed with:
_____
_____

List any medications, supplements, vitamins and over the counter medications your child is currently taking. (Please include aspirin, ibuprofen, antacids): _____
_____
_____

List all surgeries or hospitalizations: _____
_____

History

Does your child have any chronic illnesses? □ Yes □ No If yes, what type? _____

Does your child have mononucleosis? □ Yes □ No

Personal Habits

- Drink diet drinks? □ Yes □ No If yes, how many per day? _____
- Drink soft drinks? □ Yes □ No If yes, how often? _____
- Drink water? □ Yes □ No If yes, how many glasses per day? _____ □ Tap Water □ Purified Water

Recent Health History

Does your child have allergies? □ Yes □ No If yes, to what?

_____

How often does your child get colds, flu, sinusitis, bronchitis?

_____

When was the last time your child had antibiotics?

_____

Does your child have trouble falling asleep? □ Yes □ No

Does your child have trouble staying asleep? □ Yes □ No

What is your child's energy level? □ Low □ Medium □ High

What is your child's level of stress? □ Low □ Medium □ High

Does your child have?

Sugar cravings? □ Yes □ No Carbohydrate cravings? □ Yes □ No Salt cravings? □ Yes □ No

Do you exercise? □ Yes □ No If yes, how often and what type of exercise? _____

Panic attacks? □ Yes □ No Seizures? □ Yes □ No

Bowel Movements:

How many per day? _____ Per week? _____

Routinely have diarrhea? □ Yes □ No...Constipation? □ Yes □ No …Undigested food particles? □ Yes □ No

What color is the stool normally? □ Dark Brown □ Medium Brown □ Yellow/Green □ Other _____

Dental History

Does your child have mercury fillings? □ Yes □ No If yes, how many? _____

Crowns or bridges? □ Yes □ No

Root canals? □ Yes □ No If yes, how many? _____