PEDIATRIC LIFESTYLE ASSESSMENT FORM

(For children up to the age of 12 years)

Name of child: _____

Date: _____ **Age:** ____ **Sex:** ____

Please answer each of the following questions. If you require additional space, please use the back of the page.

What is your main purpose in coming here today? _____

_____

What are your child's main health concerns/complaints? _____

_____

Has he or she ever been diagnosed with an ailment related to their main health concern(s)? _____

Has there been any trauma or loss in the last 5 years? _____

Does your child live with you: Full time ☐ Part time ☐

If part-time, what percentage of time do they spend at each home? _____

Is your household a blended family? Yes ☐ No ☐

How many siblings does your child have and what are their ages? _____

How many step siblings does your child have and what are their ages? _____

Is your child adopted? Yes ☐ No ☐

If yes, at what age was your child placed with you? _____

If your child was older than a newborn at the time of placement, has your child experienced multiple placements (birth family, orphanage, foster care, etc.)? _____

_____

What level of stress is your child experiencing at this time? (Possible signs of stress include: anxiety, nightmares, overreactions, difficulty leaving you, new unhealthy patterns) _____

_____

Minimal ☐ Average ☐ Considerable ☐ Unbearable ☐

What are the major causes or factors involved in his or her stress? (Check all that apply)

Personal ☐ Family ☐ Friends ☐ School ☐ Health ☐ Other _____

How does your child's stress manifest itself? _____

_____

Does he or she have any coping mechanisms? _____

What does your child do for exercise? (Indicate type, frequency and time) _____

_____

How many hours on average does your child sleep daily? (Include naps) _____

What time does your child go to sleep at night? Awaken? _____

Does your child awaken feeling rested? Yes ☐ No ☐

What does your child do for extra-curricular activities? _____

_____

Does he or she enjoy these activities? _____

How many hours a week does your child do these activities? _____

Does anyone in your household smoke? Yes ☐ No ☐

How many hours does your child spend, on average?

in the car ____ watching television ____ reading ____ in front of computer ____

What are your child's interests or hobbies (other than his or her extra-curricular activities)? _____

_____

Does your child vacation regularly? Yes ☐ No ☐

When was his or her last vacation? _____

_____

Does your child actively participate in any spiritual discipline (church, religious group, meditation, etc.)? Yes ☐ No ☐

Is your child regularly in the care of someone other than your spouse i.e. daycare? _____

_____

MEDICAL HISTORY:

Please list any vitamins, minerals, herbal, homeopathic remedies your child is currently taking and the amounts/dosages: _____

_____

Does your child have any allergies or sensitivities? If so, please list: _____

_____

Does your child have any silver mercury fillings? Yes ☐ No ☐

Does your child have a history of prenatal drug/alcohol exposure? Yes ☐ No ☐

Has your child ever been:

Diagnosed with an illness? Explain: _____

Hospitalized? Reason: _____

How often does your child have a bowel movement? _____

Does he or she strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐

Related to a particular food or circumstance? _____

Does he or she have loose bowel movements? Yes ☐ No ☐ Occasionally ☐

Related to a particular food or circumstance? _____

MEDICAL HISTORY:

☐ ADD/ADHD	☐ Dental problems	☐ Neural Tube Defect
☐ Allergies (environmental)	☐ Developmental problems	☐ Pneumonia
☐ Allergies (food)	☐ Diarrhea	☐ Rubella
☐ Asthma	☐ Ear infections	☐ Rheumatic Fever
☐ Autism	☐ Frequent colds	☐ Scarlet Fever
☐ Blue Baby	☐ Impaired speech	☐ Tonsillitis
☐ Bronchitis	☐ Jaundice	☐ Thrush
☐ Chicken Pox	☐ Measles	☐ Whooping cough
☐ Colic	☐ Meningitis	☐ Other (specify):
☐ Croup	☐ Mumps	

SYMPTOMS: (mark C for current and P for past symptoms)

___ Abdominal pain	___ Excessive fatigue	___ Nightmares
___ Acid reflux	___ Excessive perspiration	___ Night sweats
___ Anemia	___ Flat feet	___ No appetite
___ Bad breath	___ Frequent headaches	___ Nosebleeds
___ Bed wetting	___ Gas	___ Painful urination
___ Bleeding gums	___ Hearing loss	___ Parasites
___ Blood in urine	___ Heart murmur	___ Psoriasis
___ Body odour	___ High fevers	___ Rash
___ Bruises easily	___ Hives	___ Sensitive to light
___ Canker sores	___ Hyperactivity	___ Sleep problems
___ Changes in appetite	___ Itchy anus	___ Stomach aches
___ Congestion	___ Itchy nose (or picks nose)	___ Sore throat
___ Constipation	___ Itchy vagina	___ Teeth grinding
___ Cough	___ Jaundice	___ Talks in sleep
___ Cries easily	___ Joint pains	___ Walks in sleep
___ Diarrhea	___ Migraines	___ Weight gain
___ Dizzy spells	___ Motion sickness	___ Weight loss
___ Dry Skin	___ Nervousness	___ Wheezing
___ Eczema		___ Vomiting spells

NUTRITIONAL SUPPLEMENTS
(please list). Include herbal and homeopathic as well. _____
_____
_____
_____

MEDICATIONS. Indicate length of time child received each medication.

☐ Antacids	☐ Declectin	☐ Methylphenidate (Ritalin)
☐ Antibiotics	☐ Decongestant	☐ Oral Steroids
☐ Antidepressants	☐ Dextroamphetamine (Dexedrine, Dextrostat, Adderall)	☐ Pemoline (Cylert)
☐ Anti-Histamine	☐ Epilepsy medication	☐ Tylenol
☐ Aspirin	☐ Ibuprofen	Others (please list)
☐ Clonidine	☐ Inhaled Steroids	

Are you aware of any allergies to medications? _____
_____
_____
_____

IMMUNIZATIONS: (check all that apply)

☐ Diptheria	☐ Influenza	☐ IPV (Polio)
☐ DPT	☐ Measles	☐ PNEU (Pneumoccocal disease)
☐ Hemophilus	☐ MENI (Menigococcal disease)	☐ Small pox
☐ Hepatitis	☐ MMR (Measles, Mumps, Rubella)	☐ Tetanus
☐ Hib (Hemophilus Influenza)	☐ Mumps	☐ VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, at what age? _____

_____

_____

_____

FAMILY MEDICAL HISTORY:

Hereditary Diseases:

Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

____ Heart Disease	____ Diabetes	____ Allergies
____ Hypertension	____ Arthritis	____ Mental Illness
____ Intestinal Disease	____ Osteoporosis	____ Alcoholism
____ Asthma	____ Ulcers	____ Gall Bladder Problems
____ Kidney Dysfunction	____ Cancer, type:	_____

Other (please list): _____

_____

MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)

☐ Alcohol, Cigarettes, Drug Consumption	☐ Gestational Diabetes	☐ Stress
☐ Anemia	☐ Hypertension	☐ Thyroid problems
☐ Bleeding	☐ Nausea	☐ Uterine infection
☐ Dental problems	☐ Physical or Emotional Trauma	Other, please specify: _____
☐ Diabetes	☐ Pre-eclampsia	

MEDICATIONS WHILE PREGNANT: _____
_____
_____
_____

MEDICATIONS WHILE NURSING (Mother): _____
_____
_____
_____

TERM:
Full ____ Premature ____ Late ____
Weight at birth _____ lb

LABOR & DELIVERY:
Was pregnancy induced?
Vaginal ____ C-Section ____ Complications during labor? _____
Medications during or after labor? _____

CHILD'S DIETARY HABITS:

Breast fed ☐ Bottle fed ☐

When was formula started? _____

When were solid foods first introduced? _____

What were the first foods introduced? _____

How many meals a day does your child eat:

Main Meals ____ Times of day: ____

Snacks ____ Times of day: ____

Does your child eat meals: With family ☐ Alone ☐ On the Run ☐ Restaurant ☐ Fast Food ☐

Are there any restrictions to your child's diet due to preferences of others – family, friends living with you, etc? Yes ☐ No ☐ if yes, explain: _____

How many ¼ cup servings of each does your child typically eat in a day:

Fruit: Fresh ____ Dried ____ Canned ____ Vegetables: Cooked ____ Raw ____

Whole Grains ____ type _____

Protein ____ type _____

Dairy products ____ type _____

Good Fats (nuts, seeds, avocado, oils) ____ type_____

Other: Specify _____

Give examples of your child's typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Does your child eat or use (Indicate "1" for "rarely", "2" for "regularly", "3" for "often"):

____ Aluminum pans ____ Margarine ____ Candy

____ Microwave ____ Fried foods ____ Refined foods

____ Luncheon meats ____ Nutra-Sweet/Aspartame

Please indicate how many cups of the following your child drinks per day:

____ Tap water ____ Bottles or spring water

____ Soft drinks (Diet) ____ Milk (1% or 2%)

____ Soft drinks (Regular) ____ Milk (Skim)

____ Fruit juices (Prepared) ____ Tea

____ Fruit juices (Fresh) ____ Herbal Tea

____ Vegetable juices (Fresh) ____ Pop

____ Other

Is your child a: Meat eater? ☐ Vegetarian? ☐ Vegan ☐

How often does your child eat meat? Daily ☐ 3-5/week ☐ Once/week or less ☐

How often does your child consume dairy products? Daily ☐ 3-5/week ☐ Once/week or less ☐

What are your child's favourite foods? _____

How often does he or she eat them? _____

Does your child avoid certain foods? If so, why? _____

Does your child experience any symptoms if meals are missed? Explain: _____

_____

Does your child experience any symptoms after meals? Explain: _____

_____

Comments: _____

_____

_____

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.

Date: _____

Signature of parent: _____

Name of parent (please print): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (H) _____ (B) _____

Thank you for your cooperation.

All information contained in this form will be kept strictly confidential.