Pediatric Intake Questionnaire

Basic Information

Child's Name: ______________________ Parent Contact Name: ________________________

Best email to communicate: ____

Mailing Address: ____

Preferred phone number: __________________________

How do you prefer to be contacted for check-ins?

Email Text Phone Call Instagram DM

How did you hear about my services? ____

Birthdate: ____________ Age: ______ Weight: _________ Height: _________

Health Profile

Please circle any other practitioners your child has worked with:

Chiropractic - Naturopathic - Counselor - Homeopath - Massage - Reflexologist

Personal trainer - Colon Hydrotherapist - Other: ___________________________

List one to five health goals you would like to see for your child, in order of priority:

Your child hasn't felt well since: ____

What do you suspect is the reason for his/her current condition(s)?

Please include dates where possible on the rest of this page's questions:

Do they have a recent medical diagnosis?

Have they had any surgeries?

Past Conditions or health information you'd like me to know - include their birth experience and any childhood illnesses:

Please list the vaccines your child has received and when:

List any Family Health Concerns:

Do they have any physical traumas or accidents? Broken bones? Concussions?

Stress Profile

What stressors are currently in your child's life?

What are your child' hobbies? Include any sports or extracurriculars they participate in:

Medicinal Profile

List any medications he or she has taken or are currently taking

Medication:	Date Started:	Reason:

List any supplements they are currently taking

Supplement:	Amount:	Reason:

Lifestyle Profile

On a scale of 1 to 10, rate the following:

Their current energy levels ______ Their current bowel movements ________
Their current sleep quality ______ Their current overall quality of life ________

Please describe your child's sleep schedule (include time of bed, waking, and any frequent or recurring wakeups or problems in the night)

How much water do they drink per day? ____________________

Does he or she consume caffeine? How many cups per day? __________

How often do you have a bowel movement? _________

What do their poops smell and look like?

Do they have any known food intolerances?

Any severe allergies?

Circle any of the following they consume:

Raw fish - Black Tea - Green Tea - Pop - Concentrated Fruit Juice

Fresh pressed juice - Artificial Sweeteners - Smoothies - Herbal Teas

Milk - Cream - Margarine - Canola Oil - Pork - Candy

Circle any of the following they (or you) use and indicate how much beside each circled one:

Cell Phone - Laptop - Desktop computer - Smart Home Devices

Electric Blanket - Antiperspirant - Perfume/Hairspray - Pesticides on Lawn/Garden

How is your child physically active?

How old is your home? Remodeling/construction? Carpets? Paint?

List 5 foods that your child loves, and how often they eat them:

Please circle any equipment that you have in your kitchen:

Water filtration system - High speed blender - Food processor - Juicer
Air fryer - Microwave - Toaster Oven - Immersion Blender - Dehydrator

Does your child have any dental fillings? Please explain if so:

Have they ever received braces or a retainer?

Have they ever been prescribed antibiotics? If you included this in the medication section, you can leave it blank. Otherwise, please list the reason and date.

What obstacles do you foresee coming up as we work together on a plan for their health?

Please complete the 3 day Food, Mood, Poop journal on the chart provided.

This information is provided for a holistic nutritional assessment. I understand that the information I am seeking is of a nutritional nature and not a medical diagnosis.

Signature: ___________________________________ Date: ______________________

Pediatric Intake Questionnaire

Name: ____________________________________ **Date:** ___________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes:

Pediatric Intake Questionnaire

Name: ______________________________ **Date:** ______________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes:

Pediatric Intake Questionnaire

Name: ___________________________________ **Date:** ___________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes: