# CHILD/TEEN HEALTH HISTORY QUESTIONNAIRE
## PREFERABLY FILLED OUT BY THE CHILD WITH PARENTAL ASSISTANCE

## PERSONAL INFORMATION

Name _____

Address _____

_____

Parent's Names:_____

Phone # _____

DOB ___ / ___ / _____ Age _____ Gender: M F

Ethnicity _____

Grade:_____

Brothers:_____Sisters:_____

School: _____

## PHYSICIAN INFORMATION

Please provide physician information below. According to the American College of Sports Medicine, it may be necessary to receive physician clearance prior to starting your weight loss and exercise program.

Name _____

Address _____

_____

Phone # _____

## SECTION #1

Height: _____ Weight: _____

## SECTION #2

Do you eat more than you would like to when you feel sad, angry, or lonely?

1. Never 3. Occasionally
2. Rarely 4. Frequently 5. Always

Are there any foods that often cause you to overeat?

Yes No

If *YES*, please list: _____

Are you presently undergoing any changes in your life? (e.g., parents divorce, moving or recently moved, new school, trouble with friends?)

Yes No

If *YES*, please list: _____

_____

_____

## SECTION #3

How did you hear of Nutrition Solutions?

_____

What are your goals: *(Please indicate all that apply)*

Lose weight Feel better overall

Learn about dining out

Learn about nutrition Improve fitness level

Other (please specify): _____

## SECTION #4

Are you presently exercising a minimum of three times per week at least 30 minutes at a time?

Yes No

If *YES*, please specify:

Running/jogging Brisk walking Biking

Dancing Soccer Swimming

Football Field Hocky Wrestling

Other *(please specify):* _____

Total hours engaged in TV watching, computer use or video games *per day*:

0-2 hrs/day

2-4 hrs/day

4-6 hrs/day

6+ hrs/day

If any, which do you enjoy the most?

_____

# CHILD/TEEN HEALTH HISTORY QUESTIONNAIRE

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### SECTION #5

*Check all that apply.*

- Last doctors office visit greater than 1 year ago
- Congenital heart disease
- Diagnosed uncontrolled hypertension (above 140/90)
- Experience frequent light headedness or fainting
- Epilepsy or seizures
- Head trauma
- Infectious mononucleosis (current)
- Physician currently restricting activity level
- Sleep apnea
- Shortness of breath while performing normal activities
- Bone or joint condition aggravated by activity
- Eating disorder
- Hernia
- Cancer
- Current physical therapy (within past 3 months)
- Diabetes
- Kidney disease

** If you marked any statements in Section #5, consult your healthcare provider before engaging in exercise.*

### SECTION #6

*Check all that apply.*

- Currently taking blood pressure medication
- Heart murmur
- Diagnosed hypercholesterolemia (above 240mg/dl)
- Asthma
- Foot problems
- Knee problems
- Back problems
- Shoulder problems
- Current smoker
- Do not currently exercise

** If you marked two or more statements in Section #6, consult your healthcare provider before engaging in exercise.*

Which of the following apply to your immediate family?

- Heart attack / cardiac related surgery prior to 50 years of age
- Strokes prior to 50 years of age
- Parent(s) with Diabetes
- Grandparent(s) with Diabetes
- Parent(s) with high blood pressure
- Parent(s) with high cholesterol
- Obesity

### SECTION #7

*Check all that apply.*

- Rheumatic fever
- Diagnosed controlled hypertension
- Don't know cholesterol
- Migraine/headaches
- Anemia
- Bronchitis
- Pneumonia
- Hyperthyroid / hypothyroid disorder
- Increased anxiety
- Depression
- Unusual fatigue
- Broken bones
- Ulcer
- Stomach or intestinal problems
- Acid reflux/Heartburn

Are you currently being treated for any other medical condition(s)?

Yes No

If *YES*, please list:

_____

### SECTION #8

Please list any medications you are currently taking and the reason.

_____

_____

_____

Please list any vitamins / herbal supplements you are currently taking.

_____

_____

Please list any allergies, including food allergies:

_____

Do you actively participate in gym class?

Yes No

If *No*, why not? _____

*Health Professional:* _____ *Date:* _____