CORAL GABLES Counseling CENTER

Children's Confidential Health History

Name: _____

Address: _____

Telephone: _____ E-mail or parents' email: _____

Age: _____ Birthday: _____ Place of Birth: _____

Height: _____ Weight: _____ Grade: _____

Why did you come for this health history? _____

_____

Do you enjoy school? Please explain: _____

_____

Do you have a large or small group of friends? _____

Who is your best friend? _____

_____

What do you do for fun? _____

_____

What is your favorite sport or activity? _____

_____

What are fun things you do with family? _____

_____

What are your favorite things to do when you are alone? _____

_____

What chores do you do around the house? _____

_____

When is bedtime? _____ When do you wake up? _____

_____ _____

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Do you ever wake up at night? _____ Do you ever have nightmares? _____

Do you get bellyaches? _____ Do you get headaches or earaches? _____

Is it hard to see or read? _____ Do you get itchy? _____

Do you have allergies or sensitivities? _____

Does anything else hurt? _____

_____

What do you eat for breakfast? _____

_____

What do you eat for lunch? _____

_____

What do you eat for dinner? _____

_____

What do you eat for snacks? _____

_____

What do you drink? _____

_____

What foods do you wish you could eat more often? _____

_____

What food do you wish you never had to eat again? _____

_____

What do you want to learn about your body and about food? _____

_____

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Anything else you want to say?