Child Assessment Form

Today's Date: ______________________

Email Address: ______________________
Mother's Name & Phone: ______________________
Father's Name & Phone: ______________________

Information about Client

Name of Client: ______________________
Date of Birth: ______________________
Current Age: ______________________
Height/Weight: ______________________

Primary Address: ______________________

Have you ever consulted with a psychotherapist? Yes_____ No_____
Have you ever consulted with a nutritionist? Yes_____ No_____
Do you have a history of any of the following conditions?
(please check all that apply)

_____Autoimmune disorder
_____Neurological diagnosis
_____Obesity
_____Chronic infections
_____Learning disability
_____Trouble remembering
_____Immune Compromise
_____ADD/ADHD
_____Frequent Ear Infections
_____Difficulty focusing on tasks
_____Speech difficulties
_____Insulin resistance

Current medications: ______________________
____

Allergies to medications: ______________________
____

Fitness and Exercise

Do you like physical activity? Yes_____ No_____
How many days per week do you exercise until you sweat? 0-1_____ 2-4_____ 5-7_____
Which activity do you prefer the most?
_____Playing outside
_____Watching TV
_____Playing video games
_____Playing organized sports
Are you on a sports team? Yes_____ No_____
What sport? ______________________
What are your favorite sports to play? ______________________

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Stress

Are you happy? Yes_____ No_____
Do you feel angry?
_____Occasionally
_____Often
Do you feel stressed out?
_____Occasionally
_____Often
Do you know how to turn off your thoughts? Yes_____ No_____
Do you know how to relax your body? Yes_____ No_____
How is your temperament?
_____Stable
_____Moody
What is your belief?
_____Life is difficult
_____Life just happens to you
Do you ever feel heavy or depressed like Eyore? Yes_____ No_____

Sleep

How many hours of sleep do you need to feel refreshed in the morning? ______________________________
How many hours of sleep do you get each night? ______________________________
Do you have trouble falling asleep? Yes_____ No_____
Do you have trouble waking up in the morning? Yes_____ No_____
How do you feel when you wake up?
_____Tired
_____Energetic
_____Grumpy
Do you read before bedtime? Yes_____ No_____

Nutrition

Have you ever been told that you have food allergies? Yes_____ No_____
List food allergies: ______________________________
____
How smart are your food choices?
_____Excellent more than 50% of the time
_____Not so smart more than 50% of the time
_____Inconsistent
_____I do not understand what a smart choice is
Do you want to learn more about smart food choices? Yes_____ No_____
How many 8 oz. glasses of water do you drink daily? 0-1_____ 2-4_____ 5-8____
What drinks do you consume other than water?
_____Soda
_____Juice
_____Milk
_____Smoothies

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	_____Plant based milk alternatives
List other beverages that you drink:	______________________
	______________________
Do you get stomach aches?	_____Never _____Occasionally _____Frequently
On average, how many servings of fruits do you eat daily?	0-2_____ 3-4_____
On average, how many servings of vegetables do you eat daily?	0-2_____ 3-4_____
How many fast food meals do you eat per week?	0-1_____ 2-3_____ 4-5_____ 4 or more_____
How many days per week do you eat breakfast?	0-1_____ 2-3_____ 4-5_____ 6-7_____
What do you typically eat for breakfast?	______________________ ______________________
Do you buy lunch at school more than twice a week?	Yes_____ No_____
What do you typically pack for a lunch?	______________________ ______________________
How many nights per week do you eat dinner at home with your family?	0-1_____ 2-3_____ 4-5_____ 6-7_____
Do you ever crave sweet treats?	Yes_____ No_____
Do you crave pasta?	Yes_____ No_____
Do you crave chocolate?	Yes_____ No_____
Do you crave caffeine?	Yes_____ No_____
Do you eat any of the following food items regularly?	(please check all that apply)

_____Almonds	_____Hamburgers	_____Soy	_____Beans
_____Walnuts	_____Flax seeds	_____Soda	_____Ice cream
_____Yogurt	_____Potato chips	_____Avocados	_____Wild salmon
_____French fries	_____Berries	_____Eggs	_____Milk
_____Beef	_____Salad	_____Cantaloupe	_____Pork

Do you take any supplements? Yes_____ No_____

List the supplements that you take: ______________________

General

List 3 things that you like about yourself:

____

____

____

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List 3 things in your life that you are thankful for:

____

____

____

If you could change 3 things about your life, what would they be?

____

____

____

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