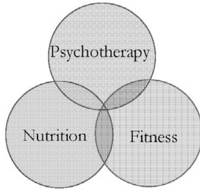


TOTAL HEALTH CONCEPTS, LLC
(703) 255-7012 / FAX (703) 255-6171

Nutrition, Fitness, and Psychotherapy Professional Services

Please Print Clearly

CHILD/YOUTH COMPREHENSIVE HEALTH ASSESSMENT FORM

Date_____/______/______

Child/Youth's Last Name _________________________ First Name _________________________ Initial___
Parent(s) / Guardian(s) ____
Address: ____State_____________Zip_____________
Home Phone: ________________________Cell: _________________________Work: ______________________
Email Address: ____

Date of Birth: _________Age: _________ Sex: M/F Height: __________Weight: ___________
School and Grade Level / Home Schooled ____

Sibling Names	Age	Sex	Any physical conditions or concerns?
________________________________	_____	M / F	______________________________
________________________________	_____	M / F	______________________________
________________________________	_____	M / F	______________________________
________________________________	_____	M / F	______________________________

Please fill in the names and phone numbers of the professionals from whom your child is currently receiving treatment:

Physician: ________________________________ Phone: ________________________________

Psychiatrist: ________________________________ Phone: ________________________________

Therapist/Psychologist: ________________________________ Phone: ________________________________

Nutritionist: ________________________________ Phone: ________________________________

Other: ________________________________ Phone: ________________________________

Who referred child/youth to Total Health Concepts?
____

Medical Diagnosis/ Primary Concerns or Problems____
____

Based on age, please have the parent or the child / youth fill out the following pages. This comprehensive assessment provides us with information that assists us in helping clients with a variety of health issues. Please fill out the sections that apply to your treatment. If you have difficulty or feel uncomfortable filling out any sections, leave them blank and your counselor/therapist will review them with you during your first session.

©2009 Total Health Concepts, LLC

Personal Health Profile

1) When was child/youth's last physical examination? ________________________________

2) Has child/youth ever been treated for or have a history of:

	Child	Parents	Siblings	Extended Family
Abdominal cramps	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Specify: _______________				
Anemia	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐
Anxiety disorders	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Behavioral problems	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐
Bulimia	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Compulsive overeating	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Emotional problems	☐	☐	☐	☐
Enuresis	☐	☐	☐	☐
Encopresis	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol/triglycerides	☐	☐	☐	☐
Hypoglycemia	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐
Meningitis	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Obesity (20+ lbs overweight)	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Substance Use / Abuse	☐	☐	☐	☐
Specify: ________________				
Thyroid Problems	☐	☐	☐	☐

Other chronic or serious health problems/symptoms: ________________________________

____

Please list any hospitalizations / surgeries / in-patient treatments and age at the time:

____

____

©2009 Total Health Concepts, LLC

Medications/Supplements

Please list all current medications, dosage, and prescribing physician:
____

Does child/youth take:
Vitamin/Mineral Supplements: ____
Aspirin/Ibuprofen: ____
Other: ____

Females Only (if appropriate age)

Regular menstrual cycle: Yes_____ No_____
Age at which menstruation began: ________
Menstrual cycle irregular/stopped? Yes_____ No_____
At what age?_______
Sexually active: Yes_____ No_____
Birth Control / Method of Protection: ________________________________

Family Profile

Birth Order: ______ of ______ children

Parented (check those that apply):
_____ Traditional Family _____ Single Parent _____ Adopted/Foster _____ Other

All People Living in Household:
____

Please list any family issues or information we should be aware of (e.g. domestic violence, CPS involvement):
____

Personal Lifestyle Profile

Hobbies/Sports/Recreational Activities:
____

Cultural/Spiritual Activities:
____

Legal Problems (arrests, juvenile convictions, court ordered treatment):
____

School Attendance/Truancy:
____

©2009 Total Health Concepts, LLC

Behavioral Profile

Please answer the following about child/youth's behavior.

	Never	Rarely	Sometimes	Frequently	Almost Always
Child/youth seems to feel stressed at school	☐	☐	☐	☐	☐
Child/youth has difficulties making or keeping friends	☐	☐	☐	☐	☐
Child/youth lacks concentration / is easily distracted	☐	☐	☐	☐	☐
Child/youth is easily irritated	☐	☐	☐	☐	☐
Child/youth complains of headaches	☐	☐	☐	☐	☐
Child/youth does not participate in activities that were previously enjoyable	☐	☐	☐	☐	☐
Child/youth seems to lack self-esteem	☐	☐	☐	☐	☐
Child/youth is "hyper" or "busy"	☐	☐	☐	☐	☐

Sleep and Behavior Pattern:
How many hours does child/youth sleep at night? ____________________________

	Never	Rarely	Sometimes	Frequently	Almost Always
Does child/youth have trouble falling asleep at night?	☐	☐	☐	☐	☐
Does child/youth wake up during the night?	☐	☐	☐	☐	☐
Does child/youth sleep walk?	☐	☐	☐	☐	☐
Does child/youth have nightmares/terrors?	☐	☐	☐	☐	☐
Does child/youth have bed wetting problems?	☐	☐	☐	☐	☐
Is it difficult to wake child/youth up in the morning?	☐	☐	☐	☐	☐
Is child/youth tired during the day?	☐	☐	☐	☐	☐
If so what times during the day? ____________________________					
Does child/youth sleep/nap during the day?	☐	☐	☐	☐	☐
How often and for how long? ____________________________					

Drinking Behavior:
Does child/youth drink caffeinated beverages: Yes ____ No ____
What kind: ________________________________
How many per day? ______ Per week? ______
Does child/youth drink sodas: Yes ____ No ____
What kind: ________________________________
How many per day? ______ Per week? ______
Does child/youth drink water: Yes ____ No ____
How many glasses per day? ______

Growth and Weight History

Please describe child/youth's weight and growth history and any concerns. Please explain if child/youth has been at a consistent percentile, or if and when there have been changes in his/her percentile on the growth charts.

____
____
____

©2009 Total Health Concepts, LLC

If possible, please bring child/youth’s growth charts to session. Or, please fill in any weights and heights you know or can estimate for child/youth at the following ages:

Age	Weight	Height	Age	Weight	Height
Birth			7		
6 months			8		
1 year			9		
18 months			10		
2 years			11		
3			12		
4			13		
5					
6					

Nutritional Profile

Eating Behaviors:
What are child/youth’s eating behaviors of concern?
_____ Receive food as a reward/to pamper
_____ Eat to avoid coping with feelings (stress, depression, boredom)
_____ Eat or snack late at night
_____ Skip meals
_____ Have an inconsistent meal pattern/timing
_____ Overeat or eat past fullness
_____ Eat at inappropriate times (watching TV, driving, cooking dinner)
_____ Eat on the run (fast food/convenience food/vending machine)
_____ Eat too fast or rush through meals
_____ Binge or overeat without control
_____ Hoard food / Hide wrappers or evidence of food
_____ Avoid major food groups
_____ Fear of weight gain or loss
_____ Frequently eat out
_____ Crave salty foods
_____ Crave sweets (sugar, candy, chocolate, cookies)
_____ Crave fats (butter, margarine, dressings, oils)
_____ Consume artificial sweeteners
_____ Other: ____

Is child/youth currently on a special diet? Please explain:______________________________

Is child/youth allergic to any of the following?
______ Gluten ______ Egg ______ Milk ______ All Dairy ______ Nuts ______ Seafood
Other: ______________________________________

Is child/youth a vegetarian? Check all that apply:
______ Exclude Red Meat ______ Exclude Fish/Shellfish ______ Exclude All Dairy
______ Exclude Poultry ______ Exclude Eggs

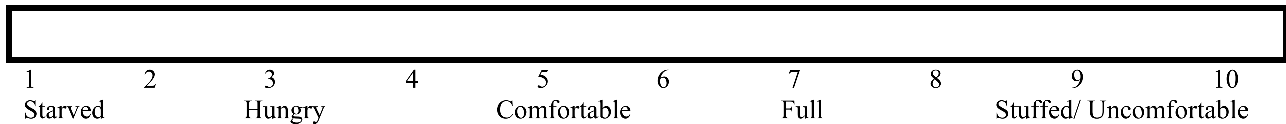
Are there any other food groups child/youth’s diet excludes?
______ Fruit ______ Vegetables ______ Starches ______ Fats
Other: ____

©2009 Total Health Concepts, LLC

What is child/youth's typical daily intake?

	Time	Activity while eating	Food/Beverages	Fill in Number of Hunger scale (see below) Before Meal	Fill in Number of Hunger scale (see below) After Meal
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					

Hunger Scale



1 2 3 4 5 6 7 8 9 10

Starved Hungry Comfortable Full Stuffed/ Uncomfortable

Estimate how many servings of the following food groups child/youth has daily:

	0-2	3-5	6-8	9+
Starches	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Protein	☐	☐	☐	☐
Fats & Sweets	☐	☐	☐	☐

©2009 Total Health Concepts, LLC

Physical and Exercise Profile

Please check all that apply.
_____ Physical impairment: ____
_____ Previous or current injuries: ____

Current Injuries/Problem Areas:

______ Back	______ Knees	______ Feet	______ Shoulders
______ Neck	______ Elbows	______ Hips	______ Ankles

Describe: ____
Other: ____

Does child/youth wear any type of arch support or orthotic?____

Exercise Goals:

______ Weight Loss	______ Posture/Balance	______ Strength
______ Flexibility/Stretching	______ Endurance	______ Sports Specific

Other: ____

Is child/youth currently involved in a regular exercise program?

______ Walking	______ Running	______ Biking	______ Swimming
______ Dance	______ Martial Arts	______ Gymnastics	

______ Team Sports: ____
Other: ____
Number times per week: ________
Minutes per session: ________

What activities does child/youth prefer?

______ Walking	______ Running	______ Biking	______ Swimming
______ Dance	______ Martial Arts	______ Gymnastics	

______ Team Sports: ____
Other: ____

Summary of Health Goals

What are the health goals for child/youth? Check all that apply:

_____ Improve academic performance
_____ Improve social behaviors and communication skills
_____ Increase self-esteem
_____ Develop self-motivation and responsibility
_____ Lose body weight/inches
_____ Improve nutritional quality and health
_____ Improved eating behaviors
_____ Improve fitness
_____ Other, specify: ____
____

What expectations and goals do you and your child/youth have for counseling/therapy sessions?
____
____
____
____

©2009 Total Health Concepts, LLC