JUNIOR HEALTH QUESTIONNAIRE

Please complete for all minors up to the age of 16 years

Life in Print
Lived experience becomes a plan

Name of parent / guardian:		
Name of child / minor:		
Address & Postcode:		
Telephone:		
Date of Birth (and Age):		
Current weight:	(lbs / kg / stone)	
Current height:	(cm / metres / feet)	
Reason(s) for completing the questionnaire today:		
Health conditions / symptoms you are seeking support for your child:		How long has she/he had this
	1.	
	2.	
	3.	
Name of GP & Practice:		

Please forward my reply:

☐ To my email below (Please print clearly)

Email:

By signing below, you are confirming that you have read and understood the Health Questionnaire Terms of Reference attached to this questionnaire (see page 9).

Signature of parent/guardian **Date:**

We will respond to your health questionnaire as soon as possible by post or email; telephone responses are not available.
Please note health questionnaire support is not intended to replace a medical consultation or practitioner consultation.
If you have health concerns it is important to obtain a medical diagnosis for your symptoms.

Please email your completed health questionnaire to help@life-in-print.com

Life in Print
Lived experience becomes a plan

Recent Consultations: Please provide approximate dates and details of any consultations:

	Date	Reason for Visit	Diagnosis / Treatments received
G.P.			
Medical Consultant			
Practitioner/ therapist. Therapy			

Please tick the box next to any of the following that apply to your child:

Does your child get any severe and/or persistent pain in any of the following:

- ☐ Head
- ☐ Abdomen
- ☐ Chest
- ☐ Eye
- ☐ Temple
- ☐ On passing urine

Other:

Does your child ever get blood in any of the following:

- ☐ Vomit
- ☐ Stools
- ☐ Urine
- ☐ Sputum

Has your child recently had any changes in:

- ☐ Level of thirst Skin
- ☐ Urination
- ☐ Breathing
- ☐ Weight
- ☐ Vision
- ☐ Body/face shape
- ☐ Personality/ behaviour
- ☐ Appetite
- ☐ Bowel movements
- ☐ Swallowing

Your Child's Health History

Has your child now or in the past experienced any of the following ? Tick if the answer is **YES**

Condition	Now	Past	Condition	Now	Past
Allergies	☐	☐	Anxiety	☐	☐
Arthritis	☐	☐	Asthma	☐	☐
Bowel problems	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Depression	☐	☐
Ear/eye/nose/throat problems	☐	☐	Drug/alcohol dependence	☐	☐
Epilepsy	☐	☐	Eczema/skin conditions	☐	☐
High blood pressure	☐	☐	Heart conditions	☐	☐
Osteoporosis	☐	☐	Menstrual	☐	☐
Stomach ulcers	☐	☐	Sleep problems	☐	☐
Urinary tract conditions	☐	☐	Thyroid problems	☐	☐

Life in Print
Lived experience becomes a plan

Other diagnosed conditions:

…… ……..

…… ……..

Digestive Function

Does your child experience the following?	**Please provide details of any which occur regularly**
☐ Abdominal bloating	
☐ Acid reflux	
☐ Bloating after meals	
☐ Burning pains in stomach	
☐ Burning pain in throat	
☐ Constipation	
☐ Diarrhoea	
☐ Diverticula	
☐ Flatulence belching	
☐ Flatulence rectal	
☐ Frequent urging to stool	
☐ Hemorrhoids	
☐ Irritable Bowel syndrome	

Female only: please indicate if monthly menstruation is present: ☐ Yes ☐ No

Is your child prescribed hormonal contraception? Please provide drug names

……

Additional menstrual info: ……..

Surgical procedures: Please provide details of any surgery and approximate dates.

……

……

Prescribed Medicines: Please list all medications your child is currently taking and include dose. This information is important to enable us to suggest safe and appropriate nutritional supplements for your child. **Please continue on a separate sheet if needed.**

Name of medication	What is it for?	Daily Dose

99 Life in Print
Lived experience becomes a plan

Non-prescription medications used: Please list any medications, laxatives, herbal products and/or homeopathic remedies that your child takes on a regular or frequent basis.

....

....

Supplements: Please list all supplements that your child is taking **currently**, dose and brand names:

....

....

Please list any **recently discontinued** medications or supplements:

....

Family Medical History. Please provide details below of family health conditions **.** e.g. Angina, Alzheimer's, Arthritis, Asthma, Blood pressure, Cancer, Dementia, Diabetes, Heart disease, Lung disease, Osteoporosis, Parkinson's disease, Stroke.

Parents

Grandparents

Siblings

Nutrition and Diet please tick those boxes that relate to your child's present diet:

- ☐ Mixed food diet (animal and
- ☐ vegetable sources) Vegetarian
- ☐ Lacto vegetarian
- ☐ Lacto ovo vegetarian
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ Calorie restriction
- ☐ Other dietary plans, please detail

Food exclusions: please list any foods you **exclude** from your child's diet**.** e.g. dairy, eggs, soy, wheat, gluten

.....

.....

Has your child taken any food allergy/intolerance tests? Please state type of test undertaken and results

.....

99 Life in Print
Lived experience becomes a plan

Food Frequency:

Fruit: How many portions of fruit does your child eat ..... **Each day** Name below those fruits that you eat regularly:

....

Vegetables: How many portions of vegetables does your child eat.....**Each day**
Name below those vegetables that they eat regularly:

....

How many slices of bread does your child eat per week of the following ?

White .... Wholemeal ..... Granary ..... Rye ..... Wheat free ..... Gluten free .....

How many portions /week does your child eat of the following?

Please insert approximate number.

Pulses, beans, lentilc..... Beef ..... Lamb ..... Pork ..... Chicken ..... Turkey.....

Eggs..... Milk ..... Yogurt ..... Cheese ..... White fish ..... Tuna ..... Salmon .....

Trout ..... Herring ..... Sardines ..... Mackerel .....

What grains does your child eat on a weekly basis? Tick boxes below

- ☐ Wheat
- ☐ Oats
- ☐ Corn
- ☐ Rye
- ☐ White rice
- ☐ Brown rice
- ☐ White Pasta
- ☐ Wholemeal pasta
- ☐ Quinoa
- ☐ Couscous
- ☐ Millet
- ☐ Bulghar wheat

Eating Habits please tick all of the following which apply.

- ☐ skips breakfast
- ☐ grazes (small frequent meals)
- ☐ regularly misses meals
- ☐ eats constantly whether or not
- ☐ hungry generally eats on the run
- ☐ adds salt to food
- ☐ adds sugar to drinks. Number of teaspoons per drink.....

Fluids - Cups per **day** of:

Coffee .... Tea ..... Green Tea ..... Herb Teas .... Decaffeinated tea or coffee .....

Cans/Glasses per **day** of:

Fizzy Drinks ..... . Cordial ..... Fruit Juice ..... Sugar free diet drinks ..... Energy Drinks .....

Water glasses (250ml) per day ..... **OR** litres per day .....

Exercise: How many days per week does your child exercise?

☐ 1-2 days ☐ 2-3 days ☐ 4-5 days ☐ 6-7 days

Duration per session: ☐ less than 30 minutes ☐ 30-45 mins ☐ 45 mins or more

Life in Print
Lived experience becomes a plan

Please describe types of exercise undertaken on a regular basis:

.....

.....

.....

How motivated are you / your child to change the way you eat and to experiment with new foods?

- ☐ *I am willing to try anything that might improve my child's condition*
- ☐ *I feel I can cope with a moderate amount of change*
- ☐ *I feel very anxious about changing my child's dietary/lifestyle habits*

Please rate your motivation on a scale of 0 to 10 (0=low; 10=high):

99 Life in Print
Lived experience becomes a plan

Food Diary
Please write down all the foods and drinks your child
Please complete as **accurately** and **honestly** as possible.

include **1** weekend day.

The following represents my child's diet for the: ☐ last month ☐ 6 months plus ☐ 1 year plus

Breakfast	Lunch	Dinner	Snacks	Fluids
Day 1	**Day 1**	**Day 1**	**Day 1**	**Day 1**
Day 2	**Day 2**	**Day 2**	**Day 2**	**Day 2**
Day 3	**Day 3**	**Day 3**	**Day 3**	**Day 3**
Day 4	**Day 4**	**Day 4**	**Day 4**	**Day 4**
Day 5	**Day 5**	**Day 5**	**Day 5**	**Day 5**

Example

Breakfast	Lunch	Dinner	Snacks	Fluids
Day 1	**Day 1**	**Day 1**	**Day 1**	**Day 1**
Porridge with honey	Ham sandwich Crisps	Roast Chicken Carrots Peas Mashed potato Apple pie & custard	Crisps Chocolate bar Apple	Tea 4 cups Coffee 1 cup Water 1 glass

Life in Print
Lived experience becomes a plan

Any additional information you wish to provide may be given below:

99 Life in Print
Lived experience becomes a plan

HEALTH QUESTIONNAIRE SERVICE – TERMS OF ENGAGEMENT

Health Questionnaire Service: This free service, which is available from our in-house Registered Nutritional Therapist, is offered to our customers as we recognise the importance of diet, lifestyle and choosing appropriate supplements as important to support health improvement. Offering this no obligation service is also in line with our charitable objectives; we are wholly owned by a charitable foundation that supports environmental and health improvement projects globally. If you complete and return the attached questionnaire, our Registered Nutritional Therapist will send you some written diet and supplement recommendations to support your health goals.

The Nutritional Therapist requests that the client notes the following:

- The degree of benefit obtainable from the recommendations may vary between clients with similar health problems and following a similar programme.
- Nutritional advice will be tailored to support health conditions and/or health concerns identified on the health questionnaire.
- We are not permitted to diagnose, or claim to treat, medical conditions.
- Nutritional advice is not a substitute for professional medical advice and/or treatment.

The parent / guardian understands and agrees to the following:

- You are responsible for contacting your child's GP about any health concerns.
- If your child is receiving treatment from his/her GP or any other medical provider you should tell them about any nutritional strategy provided by a Nutritional Therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that you tell your Nutritional Therapist about any medical diagnosis, medication, herbal medicine or food supplements your child is taking as this may affect the nutritional programme.
- If you are unclear about the agreed programme / food supplement doses / time period, you should contact the Nutritional Therapist promptly for clarification.
- You must contact the Nutritional Therapist should you wish to continue any specified supplement programme for longer than 3 months, to avoid any potential adverse reactions. In any case we recommend a regular review of supplements to ensure they remain appropriate for your needs.
- You are advised to report any concerns about your programme promptly to your Nutritional Therapist for discussion / action.
- Please note we do recommend that all supplements are taken at different times of the day to any prescribed medications.

We would always recommend you discuss any dietary or supplemental concerns or changes you wish to make with your G.P. Medication should never be discontinued or dosage amended without your G.P.'s prior knowledge and agreement.

I understand the above and agree that the health questionnaire service provided by Life in Print will be based on the content of this document. I declare that all the information we share on this health questionnaire is confidential and, to the best of our knowledge, true and correct.

Name of client: ..... **Client Signature:.....** **Date:.....**

Please submit form by attaching it to an email addressed to: help@life-in-print.com