Child Client First Time Evaluation Form

For Children 12 Years Old and Under

Angela Frieswyk, Medical Herbalist & Holistic Nutritionist, Tauranga

Please Note the following:

1. Prior to your child's very first consultation, could you please fill-in the attached form and send it to me by email to angela@herbalist.kiwi.nz or by post to 2 Westwood Street, Bellevue, Tauranga 3110. If sending your form by regular post, please ensure you post this to me at least 4 working days in advance of your child's appointment.
2. You only need to send me the "Questionnaire" part of the form, not this page nor the "Addendum to Questions" section below.
3. Allow a good 10-15 minutes to complete the form.
4. Some questions on this form are marked as "required" by showing an Asterix to the right of the question heading. Please answer these questions if you can.
5. **All information entered by you is kept strictly confidential**. The detail is used to allow me time to review your health basics and focus on priorities during your consultation.
6. If you have any recent/relevant blood tests or medical reports for you child, please bring these with you (request a copy from your doctor's clinic or specialist).

Addendum to Questions

This Addendum to Questions simply list multi choice answer options to some questions, saving space on the form you will send me. The number references below relate the question number on the Questionnaire Form.

1. Referred by Question: Options: Friend or family, My Doctor, Other medical professional, Your Website, Your Facebook page, other (please state).
2. Sleep Question: Options: Restful, Restless / Wake up often, Hard to get to sleep, Bad dreams.
3. Question on type of spread used: Butter (Salted), Butter (Un-Salted), Butter Soft Spread, Margarine, Ghee, Olive Oil Spread, I do not use any type of spread, Other Spreads.
4. Question on Diet preferences/habits. Select multiple preferences that best describe your eating habits: My child eat mostly homemade meals, my child mostly eat out, my child prefers prepped meals, my child eats mostly whole foods, my child eats a lot of convenience food, my child skip meals often, my child eats vegetarian, vegan, mostly organic, follow a specific eating plan, e.g., Keto, intermittent fasting.

Questionnaire Form

Your Child's Personal Details *:

Child's Name: _____

Age in years: _____ Date of Birth: ____/____/_____

Child's Sex: Female / Male

Parent/Guardian Details *:

Names: _____

Address: _____

_____ Postal Code: _____

Mobile Phone Number: _____ Land Line Phone Number: _____

Email Address: _____

Your Childs Doctors Name: _____ GP Practice: _____

Referred by (see Q1 of Addendum) _____

Your Child's Health *:

Please list current complaints/symptoms and rate severity (1 to 10 scale, 10 being the most severe):

Please tell me any additional information about your child's health:

Your Child's Medications/Supplements

Enter details on all your child's Medications. When listing your medications, please include details for each medication including Medication name, Dose, how long you have used it, why it was prescribed (if known).

What, if any, supplements is your child is taking?

Surgery History

Please list any surgery procedures you have had and the time period in years or months or weeks since you had this surgery.

Dental Work

Please provide details on braces, fillings, or dental problems that need attending to:

Cigarette Smoking Household

Does your child live in a non-smoking household? Yes / No

If the child is exposed to Cigarette Smoking, please provide more details e.g., how often, what is the period of exposure.

Sleep Questions and Stress Levels:

How is your child's sleep? Select options that describe your sleep patterns. (See Q2 of Addendum).

_____

Other Sleep Symptoms?

What time does your child usually go to sleep? _____ What time does your child usually awake? _____

Is your child's bedroom Dark or Light? Dark / Quite Light

Stress:

Please rate your child's current stress level (on a scale of 1 to 10, 10 being the highest) _____

What if any is the main reason(s) for your child's stress?

Family Illnesses:

Please provide details on any illnesses in the immediate family of your child.

Father Illnesses:

Mother Illnesses:

Siblings Illnesses:

Digestive, Bowel & Urination Health:

Which of the following best describes your child's digestive health/symptoms? You can make multiple selections (circle answers):

Adequate / Poor / Acid reflux / Burp often / Burning / pain in stomach / Bloating / Other _____

Bowels Motions? Daily / More than once a day / child skips days

Stool Amount: Normal / Too little / Too Large

Stool Consistency: Normal / Too hard / Too soft

Stool Colour: Brown / Black / Yellowish / Other _____

Other Stool Issues. You can make multiple selections:

None / Lots of mucus / Lots of gas / Foul smell

Any other Stool related symptoms, including pain?

Urination problems?

Circle answers: None, / Bedwetting, / Sense of urgency, / too small amount, / too large amount, / burning, / unusual smell / Other _____

Does your child need to get up out of bed & urinate several times over night? Yes / No

Has menstruation started? Not Applicable / No / Yes

Exercise Questions / Working Life Questions

Do you child exercise? Yes / Incidental exercise / No exercise

If so, what kinds of exercise do your child participate in? _____

How often your child exercise? _____

When your child exercises, how much time do they spend exercising? _____

Dietary Questions *:

Please provide consumption details of a typical day's diet for your child.

Breakfast: _____

Morning snack: _____

Lunch: _____

Afternoon snack: _____

Main meals: (Please circle option. Add the number of meals if applicable)

Red meat meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Chicken meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Fish meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Egg meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Vegetarian meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Vegan Meals: Child rarely or does not eat this option meals / ___ times a week / Every night a week.

Beverages:

Enter the number of drinks (cups) your child consumes per day.

Coffee _____, Tea _____, Green tea _____, Herb teas _____, Milk _____, Other _____

Choice of milk types (if any): _____

Other Dietary Questions:

What type of Spread does your child use (see Q3 in Addendum): _____

How many vegetables serves per day does your child consume? (1 serve = ½ cup when raw)

Fruit - Choice and number of fruits per day?

Diet preferences/habits - (see Q4 in Addendum) List options that best describes your child's diet. You can list more than one as required. _____

If your child follows a specific eating plan, e.g., Keto, intermittent fasting, please describe what specific eating plan does your child follow? _____

Appointment Day Preferences for you and your child to meet with Angela:

Please select your preferred appointment day and time of the day by ticking your preferences.

____ Any day that is available

____ Monday

____ Tuesday

____ Wednesday

____ Thursday

____ Friday

Time of Day for Appointment?

____ Any Time

____ A morning appointment

____ An afternoon appointment

Attach Medical Reports and Images?

Please attach any Recent/relevant blood tests or medical reports you may have for your child that are relevant to your appointment with Angela.

Please list details of your attachments: