Rosen Wellness
Consultation Assessment (Youth)
To be completed by Parent

General Information:

Name: _____ Date:_____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Age: _____ Date of Birth: _____ Guardian (if under 18): _____

Gender: M F Height: ___' ___" Weight: _____ lbs. Blood Type _____

Emergency contact & phone: _____

How did you hear about Rosen Wellness? _____

Major complaint(s) in order of significance to you/your child:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

How do these conditions affect your child's daily activities?

_____

_____

Why are you seeking a consultation? If you have any specific health condition, please describe it in detail including the first time you noticed the condition.

_____

_____

_____

Medical History:

Prescription Drug Usage – Please check if your child uses any of the following:

□ Antacids, Zantac, Pepcid AC, Rolaids
□ Laxatives
□ Antibiotic/Antifungal
□ Oral contraceptives
□ Hormones
□ ADD/ADHD medications
□ Relaxants/Sleeping pills
□ Antidepressants
□ Aspirin/Acetaminophen
□ Cortisone/Anti-Inflammatory
□ Anti-diabetic/Insulin
□ High blood pressure medicine
□ Statins/Cholesterol lowering medications

Please list any medications (prescription and/or over the counter) that your child is *currently* taking.

Medication:	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

List any nutritional supplements and/or herbs your child is *currently* taking.

Supplement/Herb	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Please list any major surgeries your child has had and approximate dates:

Surgery	For what:	Date:
1. _____	_____	_____
2. _____	_____	_____

How many bowel movements does your child average per day? _____

As a baby, did your child have colic? □Yes □No
As a baby, how was your child fed? *(Please circle breast or formula)*
BREAST How long? _____
FORMULA What kind? _____ How long? _____

Does your child have a history of ear infections? □Yes □No
If yes, at what age did the first earache occur? _____
How frequently did/does your child have earaches? _____
Were/Are your child's earaches/infections generally treated with antibiotics? □Yes □No
Has your child taken antibiotics within the past six months? _____

How frequently has your child taken antibiotics during their life? _____

Is your child allergic to anything? □Yes □No
If yes, please explain:
_____
Does your child have asthma? □Yes □No

Has your child been vaccinated? □Yes □No
Has he/she been vaccinated recently? □Yes □No
If yes, please list any known reactions to past or recent vaccinations:
_____
_____

Any known health conditions that your child has been diagnosed with? □Yes □No
If yes, please explain:
_____
_____

Please place an "X" next to all of the following substances that your child uses and/or consumes:

□ Tap Water
□ Coffee
□ Tea
□ Soft Drinks
□ Packaged Food
□ NutraSweet/Sweet n' Low
□ Candy
□ "Normal" Cosmetics (*not* health food store types)

Dietary Habits: Is your child a vegetarian or vegan? (Circle either if yes)

What does your child normally eat for:

Breakfast:
_____

_____

Lunch:_____

_____

Dinner:_____

_____

Number of snacks during the day: _____

Describe your child's typical snack(s):

_____

What beverages does your child usually drink and how much per day?

_____

_____

Does your child eat organic foods? □ Never □ Sometimes □ Usually □ Always

Specifically: □Fruits □Vegetables □Meat □Dairy □Boxed □Canned □Frozen

How many meals does your child eat out at restaurants during a typical week? _____

How many are at fast food restaurants? _____

Does your child crave any of the following?
□ Sugar □ Meat Fat □ Chocolate □ Fish □ Alcohol
□ Desserts □ Milk □ Bread □ Fried foods
□ Other _____

Which oils does your child use/consume?
□ Butter □ Peanut Oil □ Canola □ Margarine □ Corn Oil □ Sun/Safflower
□ Olive Oil □ Crisco □ Mayonnaise □ Coconut Oil □ Vegetable Oil □ Flaxseed Oil
□ Soybean Oil □Grape Seed Oil □ Other_____

The dairy products your child eats are mostly (circle one):
□ Full fat □ Low fat □ Skim □ I don't eat dairy products

Your child's intake of artificial sweeteners is: □ Frequent □ Occasional □ Infrequent

Does your child smoke cigarettes or use other tobacco products? □ Yes □ No
Is there a smoker in the house? □ Yes □ No

For the purposes of the following question a drink is considered to be a 12-ounce beer, a four ounce glass of wine, or a shot of hard liquor. On an average day your child has:

□ No drinks □ 1 drink □ 2 drinks □ 3-4 drinks □ More than 4 drinks

List any food allergies, restrictions, or sensitivities you are aware of:

_____

How often does your child eat the following foods? (Use the **past three months** as reference)

GRAINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Refined grains: White bread, wheat bread (not whole grain), tortilla, roll, biscuit, muffin, English muffin or bagel							
b. Cooked cereal							
c. Cold cereal							
d. Refined grains: White rice or white pasta							
e. Whole grains: 100% whole grain bread, brown rice, whole wheat pasta, or other whole grains (such as quinoa, buckwheat, amaranth, millet, barley)							

SWEETS AND SNACKS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Sweet roll, doughnut, pie, cake or cookies							
b. Candy or candy bar							
c. Salty snacks (chips, pretzels, crackers)							

FRUITS AND VEGETABLES	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cooked vegetables							
b. Raw vegetables							
c. Potato (white)							
d. French fries							
e. Piece of fruit / berries or raisins							

DAIRY/FATS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cheese (hard cheese, cream cheese)							
b. Yogurt and/or kefir							
c. Ice cream							
d. Margarine							
e. Salad dressings, mayonnaise							
f. Soy based “dairy” products							
g. Butter							
h. Olive oil							
i. Coconut oil							

PROTEINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day
a. Red meat (beef, bison)						
b. Pork, ham, bacon						
c. Poultry (chicken, turkey, duck)						
d. Fish or seafood						
e. Nuts and/or seeds						
f. Soy based protein						
g. Pizza						
h. Eggs						
i. Protein smoothie (whey, rice, pea)						

How long have you eaten this way? _____

Lifestyle:

Is your child physically active daily? □ Yes □ No
Approximately how many hours per day? _____
Please list what types of physical activity and/or sports that your child participates in:

_____

_____

Please rate the following:
Daily energy level: □ Excellent □ Good □ Fair □ Poor
Energy level after exercise: □ Excellent □ Good □ Fair □ Poor

Stress:

Does your child seem happy with your family life? □ Yes □ No

Does your child seem happy with their school life? □ Yes □ No

Perceived Daily stress level: □ Very High □ High □ Moderate □ Low □ None

Does your child ever eat or drink to satisfy their emotions? □ Yes □ No

Sleep:

How many hours does your child sleep? _____
Does your child sleep throughout the night? □ Yes □ No
Does your child wake up feeling rested? □ Yes □ No
Is your child satisfied with their sleep? □ Yes □ No

Sleep issues:
Trouble falling asleep? □ Yes □ No
Trouble staying asleep? □ Yes □ No
Insomnia? □ Yes □ No

Has your child ever been on a restricted or specific diet program? □ Yes □ No

If yes, what program and what were the results?

_____

_____

Please read the following paragraph:

Restoring the body and resolving specific complaints is an ongoing process that will take some time. It is important to understand that your diet and lifestyle directly impacts both your current state of health and your future state of health. My role is to educate you and to offer ideas and recommendations that may help improve your health. However, your health is your responsibility. Therefore, you must be willing to accept full responsibility for your health. Part of this responsibility will be the requirement to prepare more meals at home, eat healthier foods, and live a healthier lifestyle.

Client Authorization:

I understand that Bernard Rosen is not a medical doctor, nor does he prescribe pharmaceutical drugs, nor does he provide medical diagnosis or surgery. He provides holistic nutritional consulting and education utilizing assessments, tests and counseling. The holistic health care philosophy is to do no harm, work on prevention, work on the root of the problem, and work on the whole person. I understand that holistic health care is not intended as diagnosis, prescription, treatment or cure for any disease, mental or physical, and is not a substitute for regular medical care.

I request that Bernard Rosen perform an evaluation and set up a program for the purpose of enhancing my health and education. Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, doctor, or any practitioner of my choice. The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

It will be important that <u>I am involved</u> with my health care and health choices. I understand that all recommendations provided by Bernard Rosen are not intended as treatment or prescription for any disease, or as a substitute for regular medical care. It is important that I continue to communicate with all my doctors during our consultations. It is important that I understand that I am a partner in this process. By signing the form I agree and give Rosen Wellness, LLC my permission to release any information and/or reports to other healthcare professionals in regards to my care.

By signing below, you acknowledge that any dietary or supplemental suggestions made by Bernard Rosen are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

I have read the statements above and understand completely and am willing to play an active role in achieving my health related goals:

Client sign and date:

_____