

## Children's Questionnaire

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail or parents email: \_\_\_\_\_

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Grade/  
Teacher: \_\_\_\_\_

On a scale of 1-10 with 10 being the best and 1 being the worst, how are you feeling today?  
\_\_\_\_\_

Do you enjoy school? Please explain and tell me your favorite and least favorite part.  
\_\_\_\_\_

Do you have a large or small group of friends? \_\_\_\_\_

Who are your friends?  
Do you have a best friend?  
\_\_\_\_\_

What do you do for fun?  
\_\_\_\_\_

Who are your family members and do you have any pets?  
\_\_\_\_\_

What are fun things you do with family?  
\_\_\_\_\_

What are your favorite things to do when you are alone?

---

---

What chores you do around the house?

---

---

When is bedtime?

---

When do you wake up?

---

Do you ever wake up at night?

---

Do you ever have nightmares?

---

Do you get bellyaches?

---

Do you get headaches or earaches?

---

Is it hard to see or read?

---

Do you get itchy?

---

Do you have allergies or sensitivities?

---

Does anything else hurt?

---

---

What do you eat for breakfast?

---

---

What do you eat for lunch?

---

---

What do you eat for dinner?

---

---

What do you eat for snacks?

---

---

What do you drink?

---

---

What foods do you wish you could eat more often?

---

---

What food do you wish you never had to eat again?

---

---

What do you want to learn about yourself?

---

---