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Date: _____

CHILD'S HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section.
Thank you.

YOUR CHILD'S NAME: _____DATE OF BIRTH_____

PLACE OF BIRTH_____HEIGHT_____WEIGHT_____

MOTHER'S NAME_____FATHER'S NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

YOUR PHONE_____IN EMERGENCY CONTACT_____PHONE_____

FAMILY PHYSICIAN_____REFERRED BY_____

Your child's main problem:_____
When did this problem start?: _____
What treatments have you tried?_____
Past medical history: Surgery_____
Trauma (accidents requiring significant medication)_____
Other_____
Any problems with: Pregnancy_____Birth:_____
Please list immunizations, with dates and any reaction you noticed:
DPT: 1st_____2nd_____3rd_____ Reactions_____
APV 1st_____2nd_____3rd_____ _____
MMR 1st_____2nd_____3rd_____ _____
Others 1st_____2nd_____3rd_____ _____
What medication is your child taking (orthodox and complementary)?_____
_____
Has s/he had many courses of antibiotics? Lots: _____Medium_____Few_____None_____
Allergies (drugs, chemicals, foods)_____
Does your child wake at night? _____How many times?_____
DIET. Would you say that your child's appetite was: good_____medium_____small_____ Is s/he choosy over food? (Y / N)_____
How much does your child have of the following each day? Cows Milk_____Cheese_____Cola_____
Juice_____Oranges_____Bananas_____Sugar_____Sweets_____
Does s/he take dietary supplements?:_____If so which type?_____

GENERAL

___Recurrent infections
___Sweating
___Sweating on head
___Sweating after feeding
___Strong thirst
___Fatigue
___Sudden energy drops
___Underweight

SKIN

___Pimples
___Rashes
____Itching
___Eczema
___Oozing
___Pimples

HEAD EYES

EARS NOSE THROAT

___Tonsillitis
___Headaches
___Earache
___Discharge from ear
___Vision problems
___Squint
___Spectacles
___Sore eyes
___Watering eyes
___Nose bleeds
___Nasal discharge
___Blocked nose
___Snoring
___Sore throats
___Tonsillitis

DIGESTION

___Colic
___Loose Stools
___Evil smelling stools
___Green stools
___Constipation (does not go every day)
___Painful to pass stools
___Gas
___Swollen tummy
___Protruding umbilicus
___Other digestive problems
___Teething Problems

GENITO-URINARY

___Pain on urination
___Blood in urine
___Leakage in day
___Wets bed
___Rashes

MUSCULOSKELETAL

___Wry Neck
___Aching Back
___Clicky Hips
___Overweight
___Hernia

NEUROLOGICAL

___Seizures
___Nerve damage
___Paralysis

DEVELOPMENTAL

___Small for age
___Large for age
___Late developer
___Retarded

BEHAVIORAL

___Difficulty in concentrating
___Vacant
___Moody
___Aggressive
___Temper tantrums
___Autism
_____Other

WHAT THERAPIES HAVE YOU TRIED?

___Acupuncture
___Homeopathy
___Herbology
___Naturopathy

ANYTHING ELSE

_____
_____
_____
_____
_____
_____

COMMENTS

_____
_____
_____
_____
_____
_____
_____

RESPIRATORY

___Phlegm
___Recurrent cough
___Bronchitis
___Pneumonia
___Asthma