V10

Child History Record

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(02)6162-2919 - 0403-829-313

Allow 15 minutes to complete this form (3 pages)

Child's name..... Age..... Sex..... DOB.....

Parents' names: Mother.....
Father.....

Address..... Post Code.....

Phone:
H:..... **W**:.....
Mob.....

Email.....

Health Fund.....

GP's name, address and contact number:

.....

Specialist's name, address and contact number:

.....

* For distance consultations, please indicate how we are able to contact you:
☐ Email ☐ Telephone ☐ Fax (.....)..... ☐ Skype user name.....

*Please complete the following pages **in as much detail as you can.** Providing detailed information makes it easier to accurately assess your child's health status - no detail is too small!*

***What would you like to have your child treated for**?* List complaints in order of importance

1.....

2.....

3.....

4.....

5.....

Please list symptoms, in order of severity. (First symptom the most severe)

.....

How and when did the symptoms start?

.....

Are there any other health problems? If yes, please list:

.....

What medical treatment(s) has your child had so far?

What natural therapies have you used so far?

Which of these treatments have you found to be the most effective?

Please list **current** prescribed medications

Please list current supplements – vitamins, minerals, herbs etc

Any previous homeopathic medicines? Please list

General information.

Please rate your child's energy levels (circle) [**No** energy] **0 1 2 3 4 5 6 7 8 9 10** [**high** energy]

Symptoms during sleep? Please circle: Snoring, mouth breathing restlessness, sleepwalking, night sweats, perspiration, and nightmares

Any other symptoms during sleep?

Regular wakefulness? Time of waking? Reason for waking?

What **position** does your child usually sleep in?

How is your child in the morning on waking?

Are there any drug, environmental, food, or other allergies? Please state

How does your child tolerate hot weather? Cold weather?

Digestion: please circle
Is there: tummy pain, bloating, burping, diarrhea, constipation, mushy stools, and wind?

Before, during or after eating?

Please describe the frequency, texture and odour of bowel motions

What are your child's favourite foods?

Which foods does your child really dislike?

Do any foods cause symptoms?

Mental/Emotional
Are there any anxieties, fears or phobias? (E.g. heights, spiders, tunnels, crowds, snakes, the dark, shyness, thunderstorms)

Medical History
An accurate, sequential time line of your child's medical history is important. Please include all traumas (include any that surrounded your child's birth), stressful events, surgeries, hospitalizations and courses of antibiotics.

0 - 1 yrs:

1 – 2 yrs:

2 – 3 yrs

4 – 5 yrs

5 - 6 yrs

6 - 7 yrs

7 - 8 yrs

.....

8 -9
yrs.....

.....

10 + years.....

.....

Family History
Please describe **all known diseases** of the following family members e.g. heart disease; high blood pressure; diabetes; cancer; skin problems (e.g. psoriasis); TB; allergies; mental illness; alcoholism

Mother .....

Father.....

Immediate family (brothers, sisters, grandparents, aunts and uncles;

.....

Please list medical tests you have had, ***in chronological order***:

TYPE OF TEST	DATE	REASON	RESULT
□ Blood test(s)			
□ X Ray(s)			
□ CT scan			
□ Ultrasound			
□ Hearing test			
□ Other			

Anything else you would like to mention?

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Where did you hear about this clinic?

☐ Word of Mouth ☐ Advertisement ☐ Brochure ☐ Yellow Pages **online**
☐ Natural Therapy Pages ☐ Personal Internet search ☐ Other .....

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