Great Health Holistic

Child Health Questionnaire

Name: _____ Age: ___ DOB _____ Weight ___ Date: _____

Address:

_____

No. and Street City/Town State Zip Code

Parent/Guardian name: _____ Telephone No. _____

Email Address: _____

Reason for appointment:

_____

Check off any symptoms that apply to your child (current or previously):

Before Birth Symptoms:

___extreme overactivity ___prolonged hiccupping ___vigorous kicking

Problems for mother or child with pregnancy and/or birth:

_____

_____

General Childhood Symptoms

___Prolonged Colic ___Excessive Spitting ___Nausea ___Repeated Vomiting
___Diarrhea ___Anorexia/Bulemia ___Constipation ___Gas/Belching ___Eczema
___Psoriasis ___Rashes ___Acne ___Dry Skin ___Dandruff ___Brittle Nails
___Dry Hair ___Warts ___Bed Wetting ___Strong Smelling Urine ___Red Cheeks
___Bladder Infections ___Excessive Drooling ___Head Banging ___Red Earlobes
___Bad Body Odor ___Fungal Infections ___Herpes ___Dark Eye Circles
___Asthma
___Bags/Wrinkles Under Eyes ___Eye Discharge ___Eye Infections ___Allergies
___Restless Legs ___Joint Pain ___Muscle Cramps ___Headaches ___Migraines
___Grinds Teeth ___Neck Pain ___Back Pain ___Scoliosis ___Shingles
___Chicken Pox ___Measles ___Mumps ___Roseola ___Fifths Disease
___Tubes in Ears ___Frequent Colds ___Chronic Congestion ___Sore Throats
___Chronic Ear Infections ___Respiratory Infections ___Sinus Infections

___Excessive Bruising ___Cold Sores ___Brittle Nails ___Hyperactivity
___Restlessness ___Lethargic ___Poor Concentration ___Spacey ___Impulsive
___Short Attention Span ___Discipline Problems ___Depression ___Irritability
___Anxiety ___Screaming or Excessive Crying ___Poor Comprehension
___Argumentative ___Moody ___Outbursts ___Destructive Behavior
___Procrastinates ___Difficulty Sleeping ___Dislike of cuddling or Being Touched
___Dyslexia ___Vision Problems ___Hearing Loss ___Juvenile Diabetes
___Excessive Thirst ___Cranky/Tired if Hungry (eating gives relief) ___Reaction to Vaccinations ___Cold Hands & Feet ___Excessive Perspiration
___Epilepsy/Seizures
___Heart Murmur ___Lupus ___Lyme ___Crohn's Disease ___Sarcoidosis
___Hepatitis ___Arthritis ___Rheumatic Fever ___Interstitial Cystitis ___Cancer (what type?:
_____
_
___Other (Please Explain)
_____

Girls:
___Non-Menstruating ___Menstruation First Began _____
___Ovarian Cysts ___Irregular Periods ___Painful periods ___Vaginal Yeast Infections

Injuries:_____
_____

Congenital Abnormalities:
_____

Other:
_____
__

List Surgeries:
_____

List Medications (Prescription and/or over the counter):
_____

List Supplements and/or Vitamins:

_____

List any food cravings:

_____

List typical beverages:

_____

We would like to remind you that in Holistic Medicine your input is very important. We ask that you do not just follow recommendations unless you fully understand them and are comfortable. Please **DO NOT discontinue ANY prescription medication without the advice of your prescribing physician.**

I fully understand that I am not under any obligation to follow recommendations and may consult my physician at any time.

Patient/Guardian Signature:

_____

Date Signed: _____