theHomeopathicpluscentre inc.
'let like be cured by like'

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CHILD Questionnaire (to be answered by the mother if possible)

Child's Name: Parents:

Address:

Phone: (day) (eve) Parents' marital status:

Date of Birth: Age: Birth weight (kg): Height (inches):

Weight (lbs): % ile (if known)

1. What is the child's chief complaint (CC)?

2. When did this problem begin? What happened in your life around that time? What do you think caused it?

3. What aggravates the CC? (certain types of foods or weather, movement, light, noise, heat/cold, being at the seashore or anything else that you can think of)

4. At what time of the day or night is CC the worst? Specify an hour if you can.

5. What symptoms can you identify that accompany the CC?

6. What was your predominant emotional state when pregnant with this child?

7. During the pregnancy, did you suffer any particular shocks or traumas or losses?

8. Did you take any drugs?

9. How did your food cravings and aversions change during pregnancy?

10. Were there any particular complications at birth?

11. At what age did the child reach these stages:

weaning	closing of fontanels	first milk teeth
talking	toilet training	first permanent teeth
crawling	walking	

12. How did the child react to these situations? Please try to think of mental and emotional reactions as well as any physical symptoms that may have developed.

    Vaccinations

    Birth of younger sibling

    Starting day care regularly

    First day at school

    Spending the night with a friend

    Travelling with the family

    Going away to camp etc. without the family

13. How many rounds of antibiotics has the child had, and for what?

14. Any skin conditions treated with cortisone cream?

15. Did the child suffer from a childhood disease with very severe symptoms? (measles, chickenpox, German measles, croup, mumps, etc.)

16. When ill or upset, does the child tend to cling to you or want to be left alone?

17. What is the child's behaviour in playing with other children? Does it make a difference if the other kids are older or younger?

18. What feedback do you get from your child's teachers about behaviour in class?

19 What pets do you have, and what is your child's attitude towards them?

20. a) What types of food does your child crave? Please be as specific as possible and list as many as you can.

    b) What types of food does she/he refuse to eat?

    c) What types of food does your child react badly to, whether physically (bloating, diarrhea, etc.) or behaviourally, and what are the reactions?

21. Any fears that are unusual for a child of your child's age (of the dark, being alone, lightning, thunder, etc.) Are there nightmares?

22. Is the child chilly? Is there excessive perspiration on the head and/or feet?

23. Is the child very affectionate when not sick?

24. Is the child unusually sympathetic (showing concern for the suffering of other children, animals, etc.)?

25. Does the child like music? What kind? Like dancing? Do symptoms (like restlessness) improve with music?

26. Is the child obstinate? How is this expressed?

27. Is the child fastidious?

28. Is the child sensitive to criticism and reprimand?

29. Can you think of any unusual or distinctive things about your child—behaviour, fears, fantasies, desires, attachments, preferences in clothing, etc.?

30. Give a timeline for the child with all possible traumas, diseases, important events, deaths in the family. Describe the reaction of your child towards these events.

PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name: ____________________________________ Date: ___________________________

Age: _____________ Date of Birth: ______________________________ Sex: F _____ M _____

SYMPTOMS: (mark C for current and P for past symptoms)

____ Abdominal pain	____ Excessive fatigue	____ Nightmares
____ Acid reflux	____ Excessive perspiration	____ Night sweats
____ Anemia	____ Flat feet	____ No appetite
____ Bad breath	____ Frequent headaches	____ Nosebleeds
____ Bed wetting	____ Gas	____ Painful urination
____ Bleeding gums	____ Hearing loss	____ Parasites
____ Blood in urine	____ Heart murmur	____ Psoriasis
____ Body odour	____ High fevers	____ Rash
____ Bruises easily	____ Hives	____ Sensitive to light
____ Canker sores	____ Hyperactivity	____ Sleep problems
____ Changes in appetite	____ Itchy anus	____ Stomach aches
____ Congestion	____ Itchy nose (or picks nose)	____ Sore throat
____ Constipation	____ Itchy vagina	____ Teeth grinding
____ Cough	____ Jaundice	____ Talks in sleep
____ Cries easily	____ Joint pains	____ Walks in sleep
____ Diarrhea	____ Migraines	____ Weight gain
____ Dizzy spells	____ Motion sickness	____ Weight loss
____ Dry Skin	____ Nervousness	____ Wheezing
____ Eczema		____ Vomiting spells

For Office Use Only:

MEDICAL HISTORY: (check all that apply)

❒ ADD/ADHD	❒ Dental problems	❒ Neural Tube Defect
❒ Allergies (environmental)	❒ Developmental problems	❒ Pneumonia
❒ Allergies (food)	❒ Ear infections	❒ Rubella
❒ Asthma	❒ Frequent colds	❒ Rheumatic Fever
❒ Autism	❒ Impaired speech	❒ Scarlet Fever
❒ Bronchitis	❒ Measles	❒ Tonsillitis
❒ Chicken Pox	❒ Meningitis	❒ Whooping cough
❒ Croup	❒ Mumps	❒ Other (specify):

Nutritional Supplements (please list). Include herbal and homeopathic as well.

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MEDICATIONS. (check all that apply, and indicate the length of time the child received each medication.

❒ Antacids	❒ Declectin	❒ Methylphenidate (Ritalin)
❒ Antibiotics	❒ Decongestant	❒ Oral Steroids
❒ Antidepressants	❒ Dextroamphetamine (Dexedrine, Dextrostat, Adderall)	❒ Pemoline (Cylert)
❒ Anti-Histamine	❒ Epilepsy medication	❒ Tylenol
❒ Aspirin	❒ Ibuprofen	❒ Others (please list)
❒ Clonidine	❒ Inhaled Steroids	❒

Are you aware of any allergies to medications?

IMMUNIZATIONS: (check all that apply)

❒ Diptheria	❒ Influenza	❒ IPV (Polio)
❒ DPT	❒ Measles	❒ PNEU (Pneumoccocal disease)
❒ Hemophilus	❒ MENI (Menigococcal disease)	❒ Small pox
❒ Hepatitis	❒ MMR (Measles, Mumps, Rubella)	❒ Tetanus
❒ Hib (Hemophilus Influenza)	❒ Mumps	❒ VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, at what age?

MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)

❒ Alcohol, Cigarettes, Drug Consumption	❒ Gestational Diabetes	❒ Stress
❒ Anemia	❒ Hypertension	❒ Thyroid problems
❒ Bleeding	❒ Nausea	❒ Uterine infection
❒ Dental problems	❒ Physical or Emotional Trauma	❒ Other (specify):
❒ Diabetes	❒ Pre-eclampsia	

For Office Use Only:

MEDICATIONS WHILE PREGNANT:

MEDICATIONS WHILE NURSING (Mother):

TERM:

Full ____ Premature ____ Late ____

Weight at birth ________________ lb

LABOR & DELIVERY:

Was pregnancy induced? ____

Vaginal _____ C-Section _____ Complications during labor? __________________

Medications during or after labor? ____

FEEDING:

Breast fed _____ Bottle fed _____

When was formula started? ____

When were solid foods first introduced? ____________________________________

What were the first foods introduced? ______________________________________

____

Did your baby have any of the following problems?

____ Jaundice

____ "Blue Baby"

____ Colic

____ Diarrhea

____ Thrush