**Questionnaire**

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| Child’s Name:  | Date:  |
| Parent’s Name(s):  | Date of Birth:  |
| Address:  | Email:  |
| City, St, Zip:  | Phone:  |

**CHIEF COMPLAINT**

What is the chief complaint for your child?

What do you think caused it?

When did this problem begin?

What happened in the child’s life around that time.

What aggravates this complaint? (*Certain types of foods or weather, movement, light, noise, heat/cold, etc.*).

What improves the complaint or makes it feel better?

At what time of the day or night is the chief complaint worse?

What other symptoms accompany this complaint?

**PHYSICAL**

Has your child had any of the following diseases or conditions?

Measles

Mumps

Chickenpox

Croup

Whooping cough

Rubella

Staph Infection

Sinus infection

Eye inflammation (Conjunctivitis, Pink Eye, discharge of any kind, etc)

Enlarged tonsils / adenoids

Tonsillitis (*Strep Throat*)

Mononucleosis

Ear infections

Mumps

Asthma

Chest colds

Bronchitis

Pneumonia

Yeast (Thrush, Candida)

Urinary Tract Infections

Skin rashes such as eczema, diaper rash

Warts

Cancer

How often does your child get sick?

What medications or treatments have you used during your child’s illnesses?

Are these illnesses accompanied by fevers? If so, how high do they go?

Does he have any problems with digestion? Please explain

How frequent are your child’s bowel movements?

Are bowel movements normal, loose, or difficult?

If there are skin problems, how are they treated?

Has your child been vaccinated?

Did your child have any reactions to a vaccine such as sudden sleepiness, incessant crying, swelling, respiratory difficulties, rash, vomiting, or fever?

Is your child generally warm or cold?

At what time of the day is your child’s energy level at its highest and lowest?

Has your child been hospitalized, and if so, for what?

**MENTAL EMOTIONAL**

Does your child have any nervous habits, such as nail biting?

Are there any learning or behavioral problems at home or in school?

**SLEEP**

Does your child have any sleep problems?

Does (s)he have night terrors, nightmares, or recurrent dreams?

What time does your child go to sleep at night and wake up in the morning?

**FOOD AND DRINK**

What are you child’s food likes and dislikes?

Does (s)he have any food sensitivities or allergies?

Does (s)he like eggs or dairy?

How thirsty is your child? What beverages does your child drink, and how often?

Is (s)he on a special diet? If yes, please explain.

**MEDICATION / SUPPLEMENTS / REMEDIES**

What are the medications that your child is currently taking or has taken in the past? (*please include antibiotics, steroids, anesthesia*)

What vitamins or herbal supplements is (s)he taking?

Please give a previous history of homeopathic treatment if there is one, and list the remedies given.

**FAMILY HISTORY**

List current conditions and diseases of family members within at least one generation, and causes of death for parents, siblings, grandparents.

**ADDITONAL COMMENTS**