TWO LEGS AND FOUR HOMOEOPATHIC HEALTH

131 Loton Road, Millendon 9296 0152

CHILD (10 years and under) MEDICAL BACKGROUND FORM

Please fill out what you can and email it back to me before the consultation. This is not compulsory, but it does save time.

All details of this questionnaire are strictly confidential.

I refer to the child as 'they' rather than 'him' or 'her' for ease.

Date:

Child's name:

Date of birth:

Place of birth:

Parents names:

Address:

Daytime phone, if in Australia:

Mobile, if inAustralia:

e-mail address:

Where/who did you hear about me:

Current Health Concerns

What is your child's main complaint, the complaint that bothers you the most, which you want fixed as a priority?

When did it first start?

List any other complaints?

When did they start?

Please list any medication your child is taking on a regular basis, including health supplements:

Environment

Please detail any environmental factors which affect your child. Listed are some examples, but there may have more.

Seasons
Heat/Cold
Humidity

Dry weather
Change in weather
Wind
Thunderstorms
Phases of the moon
Stuffy, closed or warm room
Fresh air
Sea
Sun
Being in the bush
Mountainous regions
Smoke

Health History

Under the headings below, please list any past illnesses, injuries, major traumas that affected your child strongly, including the approximate age. Please include any information that seems interesting or unusual. Don't leave out anything important.
Please detail the medical treatment received as well as any adverse reactions to the treatment.

Illnesses

Injuries, Traumas - Physical or Psychological

Mother's Pregnancy

THIS IS IMPORTANT!
Please detail anything about this including any medical interventions.

Please indicate if IVF was used.

Please indicate what contraceptions were used prior to conception.

Please indicate how long it took to conceive.

Vaccine History

Please give details of past vaccinations with your approximate age or the dates, including any adverse reactions. The common ones are listed below, to help you:

DTP
Polio
Whooping cough/Pertussis
MMR
Chicken pox
HIB
Hep A or B
PCV
BCG
Malaria
Smallpox
Typhoid
Yellow fever
Cholera

Gamma globulin
Flu
Tetanus
Gardasil
Any other vaccinations

Where there any ailments after the vaccines

Surgery, Operations

Please list any surgery your child has had, with the approximate dates:

Medical tests

Please detail the radiation tests your child has had, such as X-rays, cat scans, MRI scans, etc:

Allergies

Does your child have any allergies - from food, drugs, the environment, etc. Details when they started, the severity on a scale of 1 to 10 and if they still have them

Family History

Family history often contains very important links to where a problem lies, so please give as much detail here as you can:

If your child is adopted, it's the biological family history I would like.

Mother: year of birth:
Occupation:
Specific health problems in her life:
If died, what her age and the cause was:

Father: year of birth:
Occupation:
Specific health problems in his life:
If died, what his age and the cause was:

Sibling: year of birth:
Occupation:
Specific health problems in her/his life:
If died, what the age and cause were:

Sibling: year of birth:
Occupation:
Specific health problems in his/her life:
If died, what the age and cause were:

Please copy and paste if there are more than two siblings.

Maternal grandmother:
Specific health problems in her life:
If died, what her age and the cause was:

Maternal grandfather:
Specific health problems in his life:
If died, what his age and the cause was:

Please detail any major diseases on the mother's side of the family

Paternal grandmother:
Specific health problems in her life:
If died, what her age and the cause was:

Paternal grandfather:
Specific health problems in his life:
If died, what his age and the cause was:

Please detail any major diseases on the father's side of the family.

Please detail any major diseases in aunts, uncles, cousins.

Activities, Hobbies

Please list those activities which your child most enjoys or have problems with. Please give details. Below is a list, but there may be more.

Standing/walking/running
Sitting
Lying down
Looking up or down
Climbing or descending stairs
Reading, writing
Talking
Physical exertion
Mental exertion
Particular interests or hobbies

General

Is your child affected by any of the following:

Bright lights
Strong smells
Sudden noise
Touch
Pressure
Tight clothing
Being alone
Being in a crowd
Being in the dark
Surprises
Sympathy/Consolation
Confrontation
Criticism

Sleep

Does your child have trouble falling asleep?
How well do they sleep?

Any insomnia?
Any dreams or nightmares?
How are they on waking or rising?
Any snoring?
Any jerks or twitches during their sleep?
Any sleep talking?
Any sleep walking?

Digestion

Please detail any problems your child has with any area of the digestive tract, from the mouth to the anus.

How is the appetite?
Are there any cravings or aversions?
Are there any flavours which are strongly disliked?
How are they after eating?
Do they prefer hot or cold meals?
How thirsty are they naturally?
How much would they drinks naturally in a day?

Is there any gas or bloating?

How often do they have a bowel movement?
What is the stool like?
Is there straining or pain?

Please give me details of their typical diet.
Breakfast -
Lunch -
Tea/Dinner -
Snacks -
Drinks -

Urination

Do they have any urinary tract problems?
Is there a strong smell?
Is there any pain?
Is there any difficulty with the flow?
Is there any involuntary urination inappropriate to the age?

Perspiration

Does your child perspire much?
On what parts of the body do they perspire the most?
Does the sweat stain or stiffen the clothing?
Does the sweat have an unusual or strong odour?

Parts of the Body

Please take a few moments to run through any areas that you may not have mentioned already. If you have already detailed them in another area, just put 'as above':

Headaches
Vertigo/giddiness

Fainting
Skin/scalp
Eyes/vision
Nose/sense of smell
Mouth/sense of taste
What is the appearance of the tongue
What are their teeth like?
Did they baby teeth fall out easily to make way for the adult teeth?
Gums
Lips
Throat
Back
Limbs
Joints
Trembling/weakness
Paralysis
Skin - eruptions, warts, moles, itch, numbness, bruising, etc
Healing of injuries/wounds
Easy bruising
Finger and toe nails

Homeopathy

Please indicate if your child has had a consultation with a homeopath before and if so, what remedies were prescribed.

Please indicate any homeopathic remedies they have taken without a consultation.

What are your expectations from your child’s homoeopathic treatment with me?

Comments

CONGRATULATIONS in completing this marathon questionnaire! This is a significant step in your child’s journey to wellness.

Re-scheduling or Cancellations

Homeopathic consultations take time. My appointments are lengthy to discover the core reason for your ill health. So cancellations or failure to arrive for an appointment makes a big impact on my day.

Inevitably there are times where you need to cancel or re-schedule your appointment. Wherever it is possible, I do appreciate you giving me as much notice as possible, at least 24 hours is preferred. Often, people ring me early in the day for an appointment and it is frustrating for us both when there is apparently no free slot, which ultimately becomes available.

Those who fail to come to a prearranged appointment or don’t give me 24 hour advance notice may be charged for the full consultation.

I appreciate your consideration.