artofhealing
naturopathic medicine

Children's Health Appraisal Questionnaire




Complete the following questionnaire for your child.
Answer all relevant questions in as much detail as you can.

Today's Date: _____

Child's name: _____

Parent's names: _____

Child's age: _____ Child's DOB: _____ Child's sex: _____

Address: _____

_____

Phone (home): _____ (work): _____ (mobile): _____

Email: _____

Fax: _____

Reason for your child having this naturopathic consultation:

List your child's symptoms or conditions you would like improved or treated in this consultation.

1. _____

2. _____

3. _____

4. _____

Current Medical History:

List any conventional medications your child is currently taking.

_____

_____

Is your child allergic to anything? (eg. foods, medications, pollens, chemicals, moulds, animal hair)

_____

_____

List any vitamin or mineral supplements, herbs or homoeopathic remedies your child is currently taking? (Include dosages)

_____

_____

Is your child currently seeing any other practitioners? (eg. acupuncturist, osteopath, chiropractor, physiotherapist, counsellor)

_____

_____

Has your child had any medical tests or investigations lately? (Include reason for test and results)

_____

_____

Has your child been immunised? (Did they have a reaction to any of the vaccines?)

_____

_____

I feel that my child has not felt well since…….. (eg. a particular event, illness, loss or trauma)

_____

_____

My child:

- [ ] is currently being breastfed.
- [ ] is formula fed. (Name of formula) _____
- [ ] is formula fed with a cow's milk based formula.
- [ ] is formula fed with a soy based formula.
- [ ] was breastfed as a baby.

Is your baby having any problems breast feeding?

_____

How many times a year does your child get a cold or flu?

_____

How many courses of antibiotics has your child had? (When was the last course taken?)

_____

Does your child suffer from any of the following conditions?

- [ ] diabetes
- [ ] ADD/ADHD
- [ ] learning difficulties
- [ ] recurrent tonsillitis
- [ ] epilepsy
- [ ] migraines
- [ ] behavioural problems
- [ ] recurrent earaches and ear infections
- [ ] cancer
- [ ] headaches
- [ ] asthma
- [ ] overweight

Give details and symptoms of the conditions above. (How long has your child had condition, frequency, what makes symptoms better or worse, treatments and if successful?)

_____

_____

Is your child a late developer? (eg. crawling, teething, walking, talking)

_____

_____

Sleep and Energy Levels:

Does your child have any problems getting to sleep or staying asleep? (Explain)

_____

_____

List any possible causes of your child's sleeping problems. (eg. scared of the dark, frequent nightmares, worrying about something happening at school)

_____

_____

Does your child complain of having nightmares frequently?
(What are they about, is there a recurring theme?)

Is your child scared of the dark?

Does your child wake at any certain times during the night? (Explain possible cause eg. to go to the toilet, wet the bed, thirsty, nightmares, breast or formula feed)

What are your child's energy levels like?

Does your child have an energy slump at a particular time of the day or night?

Does your child feel tired and lethargic after eating?

Diet Dairy:

Fill out the following diet diary in as much detail as possible.
(Include portions, beverages, roughly the time of each meal, and breast or formula feeds if relevant).

What does your child eat and drink during a normal day?

Breakfast:

Mid-morning snacks:

Lunch:

Afternoon snack:

Dinner:

Dessert:

Before bed snack:

Additional Dietary Information:

My child is: ☐ vegetarian ☐ vegan

List any other foods your child eats regularly.

List any foods that your child dislikes and won't eat.

How much water does your child drink daily?

Is your child constantly thirsty?

How many juices does your child have a day?
(What type eg. freshly squeezed, bottled, 100% juice, added sugar or fruit drink)

Does your child drink soft drink? (What type and how often?)

Does your child crave any foods? (List)

Is your child a fussy eater? (Explain)

Does your child have a large or small appetite?

Do you add salt to your child's meals?

Do you add sugar or honey to any of your child's meals or beverages? (Daily quantity)

Digestive Health:

My child is:

- ☐ Gluten-intolerant (Coeliac)
- ☐ Wheat intolerant
- ☐ Lactose intolerant
- ☐ Allergic to milk protein

Does your baby suffer from colic? (Explain what makes it better or worse eg. rubbing or lying on stomach, at night or in the morning, bending legs up, arching back?)

Does your child experience bloating and flatulence? (Explain eg. after eating certain foods)

Does your child complain of recurrent stomach aches?
(Explain eg. after eating certain foods, a particular time of day)

Does your child complain of feeling nauseous or vomiting?
(Explain eg. after eating certain foods, a particular time of day)

_____

_____

Does your child suffer from constipation?
(Explain eg. how often, after eating certain foods, when stressed)

_____

_____

Does your child complain of pain or straining when having a bowel movement?

_____

_____

Does your child suffer from diarrhoea?
(Explain eg. how often, after eating certain foods, when stressed)

_____

_____

How many bowel movements (or dirty nappies) does your child have a day?

_____

_____

Does your child have worms? (Describe symptoms)

_____

_____

Does your child complain of an itchy anus?

_____

_____

Describe your child's stool:

- ☐ hard
- ☐ contains mucus
- ☐ light, clay colour
- ☐ dark brown
- ☐ loose and watery
- ☐ contains blood Bright or dark red? _____
- ☐ mustard yellow
- ☐ undigested food particles
- ☐ like small pebbles
- ☐ green, spinach like

Do you feel that your child is overweight or underweight (or your baby is not gaining weight adequately)? (Explain)

_____

_____

Oral Health:

Does your child suffer from any of the following?

- ☐ mouth ulcers
- ☐ cold sores
- ☐ bleeding gums
- ☐ dental problems
- ☐ oral thrush
- ☐ abscess

Other: _____

Give symptoms of above condition:

_____

_____

Is your child teething at the moment?

_____

_____

Is your child suffering from any of the following teething symptoms?

- ☐ both cheeks red and flushed
- ☐ one cheek red and flushed
- ☐ excessive dribbling
- ☐ chewing on things (eg. toys, fists, clothes, blankets)
- ☐ cries alot, irritable and usettled
- ☐ waking more frequently during the night

Does your child grind their teeth?

_____

_____

Does your child have a white coating on their tongue?
(What colour eg. white, cream, yellow, green, grey and thickness?)

_____

_____

Ear and Eye Health:

Does your child suffer from any of the following conditions?

- ☐ hearing problems
- ☐ recurrent ear infections
- ☐ glue ear
- ☐ tinnitus (ringing ears)
- ☐ perforated ear drum

Other: _____

Describe the symptoms of the conditions above. (How long has your child had condition, frequency, what makes symptoms better or worse, treatments and if successful?)

_____

_____

Does your child have grommets? (When were they put in?)

_____

_____

Does your child have any eye problems?

- ☐ poor eyesight
- ☐ sticky eye, blocked tear duct
- ☐ conjunctivitis
- ☐ styes
- ☐ itchy eyes
- Other: _____

Describe symptoms of the conditions above. (How long has your child had condition, frequency, what makes symptoms better or worse, treatments and if successful?)

_____

_____

Nose and Respiratory Health:

Does your child suffer from frequent nose bleeds? (How often?)

_____

_____

Does your child suffer from any of the following respiratory conditions?

- ☐ pneumonia
- ☐ bronchitis
- ☐ hay fever (allergic rhinitis) Seasonal or all year round? _____
- ☐ breathlessness on exertion Other: _____
- ☐ wheezing
- ☐ asthma
- ☐ sinusitis
- ☐ croup

Describe the symptoms of the conditions above.
(How long has your child had condition, frequency, what makes symptoms better or worse, causative factors – pollens/animal hair/time of year, treatments and if successful?)

_____

_____

Does your child have nose bleeds often?
(Include possible cause, how often and when did they start)

_____

_____

Does your child have a cold or the flu at the moment? (Include duration)

_____

_____

Does your child have any of the following symptoms?

- ☐ clear nasal discharge
- ☐ green nasal discharge
- ☐ loss of appetite
- ☐ aching muscles
- ☐ blocked nose When is it worse? (eg. only at night, all day and night, only one nostril) _____
- ☐ cream nasal discharge
- ☐ thick nasal discharge
- ☐ sore throat
- ☐ yellow nasal discharge
- ☐ fever
- ☐ swollen glands

☐ nose runs like a tap Worse? (eg. only in the day, outside) _____
☐ cough Describe (eg. hard, dry, horse, ticklish, wet) _____
☐ productive cough (cough up sputum) What colour? _____
☐ unproductive cough (no sputum) _____
Other: _____

Urinary System Health:

Does your child urinate (or have wet nappies) regularly?

_____
_____

I have noticed that my child's urine is:

☐ clear ☐ dark yellow ☐ contains blood
☐ has a strong smell

Does your child suffer from recurrent urinary tract infections?
(Explain how often, symptoms and treatment?)

_____
_____

Does your child complain of pain or burning when they urinate? (Explain)

_____
_____

Does your child wet the bed? (How often and when did this start)

_____
_____

Skin Health:

Does your child suffer from any of the following?

☐ eczema ☐ psoriasis ☐ tinea
☐ flaky scalp ☐ warts ☐ dermatitis
☐ hives ☐ itchy skin ☐ cradle cap
☐ nappy rash ☐ boils ☐ singles (herpes zoster)
Other: _____

Describe symptoms of the condition above.
(How long has your child had condition, what makes symptoms better or worse, what treatments have you tried, where on the body, describe how their skin looks?)

_____
_____

Emotional Health:

Explain your child's usual temperament?

_____

_____

What situations, foods or beverages trigger emotional reactions in your child? (Explain)

_____

_____

Does your child have any fears or phobias? (eg. heights, spiders, the dark, new situations or people)

_____

_____

Has your child undergone some loss, bereavement, shock or trauma?

_____

_____

Please indicate if your child exhibits any of the following behaviours:

- ☐ clingy, wants to be held all the time
- ☐ highly competitive
- ☐ fear of failure
- ☐ lacks confidence
- ☐ must follow a routine
- ☐ worries not good enough
- ☐ stress and anxious
- ☐ outgoing
- ☐ cries a lot
- ☐ argumentative
- ☐ hyperactive
- ☐ misbehaves at school
- ☐ cries when put down
- ☐ perfectionist
- ☐ very sensitive
- ☐ stubborn
- ☐ independent
- ☐ shy
- ☐ destructive
- ☐ regular temper tantrums
- ☐ violent, fights
- ☐ always sad
- ☐ short attention span

How is your child performing at school?

_____

_____

Is your child social, do they have lots of friends or do they prefer to play alone?

_____

_____

Past Health History:

Describe mother's health during her pregnancy. (eg. did she suffer from anaemia, toxaemia, gestational diabetes or hypertension)

_____

_____

Did your child have a traumatic birth or were there any complications? (Explain)

_____

_____

What childhood illnesses has your child had?

- ☐ chicken pox
- ☐ measles
- ☐ glandular fever
- ☐ scarlet fever
- ☐ rubella
- Other: _____
- ☐ mumps
- ☐ whooping cough

Please list any of your child's other health events (including viruses, injuries, hospitalizations and operations) on the time line below:

0-1 years:

_____

1-2 years:

_____

2- 3 years:

_____

3-4 years:

_____

4-5 years:

_____

5-10 years:

_____

10+ years:

_____

Parent's Health History:

Are you or your partner allergic to anything?

Are you or your partner lactose intolerant?

Are you or your partner gluten intolerant?

Do you or your partner suffer from eczema, hay fever or asthma? (Explain)

If breastfeeding, list foods you eat in a normal day.
(Include beverages)

List any known diseases or illnesses in your family such as diabetes, cancer, heart disease, mental illness or mental illness.

Additional Information:

Is there anything else you would like to mention that you think may be affecting your child's health?

ONLINE NATUROPATHIC CONSULTATION CONSENT FORM

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths treat their patients holistically, taking into consideration their physical, mental and emotional aspects. Natural medicines are generally used in order to stimulate the body's inherent healing capacity. A number of different approaches are used by naturopaths such as dietary changes, nutritional supplements, herbs, homoeopathic remedies and lifestyle changes.

Naturopathic medicines are generally considered safe and side-effect-free. Although rare, negative reactions to these natural medicines can occur, such as an allergic reaction to a herb or an aggravation of pre-existing symptoms.

I understand that for a short period time my child may experience worsening of symptoms or even new symptoms - this is called a healing crisis. Although unlikely, this is generally considered a positive sign and shows the body is making positive movement, and can signal the body is detoxifying.

Natural medicines should be used with caution when treating some conditions such as in pregnancy, diabetes, heart and liver disease. It is very important therefore that you inform your naturopathic practitioner immediately of any disease process that your child is suffering from, or if they are pregnant or breastfeeding.

I understand that the interactions between herbs and prescribed drugs, are not yet well known, and that while unlikely could have an adverse reaction or experience a reduction or increase in the effect of other medications. If your child is taking a prescribed medication and/or receiving other therapies – please advise your doctor of what treatment and supplements you may be receiving. Do not alter or cease medication without advising the prescribing practitioner. This includes psychological and counseling therapies.

I realise that physical examination, which may or may not be a necessary or crucial element of my child's health assessment, will not be possible during an online consultation.

I understand that a record will be kept of my child's personal health history. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that the naturopath will answer any questions I have to the best of their ability. I understand that results are not guaranteed. I do not expect the naturopath to be able to anticipate and explain all risks and complications. I will rely on them to exercise judgment during the course of the procedure which they feel at the time is in my child's best interests, based upon the facts then known.

☐ I have fully read and understand the above information and with this knowledge, I hereby consent to my child having an online naturopathic consultation with Lisa Guy.

Date: _____

SEND MY COMPLETED QUESTIONNAIRE

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