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HEALTH APPRAISAL QUESTIONNAIRE - CHILD (short)

NAME: _____ **DATE**:_____

All case history and medical information recorded on this form and during the consultation are kept strictly confidential. Information in this questionnaire and other files will not be released to any person or agency except with your authorisation or where required by law.

Primary health concerns / symptoms

Health issue	**Severe / Moderate / Mild**	**Year of onset**

List current medications, vitamins, minerals, herbs etc. (e.g. Panadol etc)

Name of medication and /or supplement including brand name	**Dose per day** (e.g. 30g)	**Duration taken** (e.g. 3 months)	**Reason(s)** (e.g. for acne)	**Does it help?** (No / moderately/ markedly)

What other therapies have you had so far? e.g. GP advice, diet modification, homeopathy, acupuncture, chiropractic etc

Treatment	**Duration**	**Does/did it help?** (No / moderately / markedly)

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Laboratory tests performed in the past 12 months e. g. blood tests, stool analysis, hair analysis etc

Laboratory tests	When?	Outcome

Please bring copies of all tests performed in the last 12 months

Major hospital procedures – surgeries, injuries etc. Please list all procedures, complications (if any)

Surgery / Illness / Injury	Year	Outcome

Past medical conditions

Childhood (ear infections, measles, frequent antibiotics etc)	Accidents or injuries in the last 5 years and major incidents before that. Significant emotional upsets (family death, divorce, abuse etc)

How often does the child suffer from a cold or flu (times per year)?

_____

Does the child experience recurrent infections of any type? ☐ Yes ☐ No If yes, please provide details

_____

_____

How many times has the child taken antibiotics since birth? Provide details re what type of illness, when and for how long

_____

_____

_____

_____

_____

Family medical history (all known illnesses e.g. heart disease, high blood pressure, cancer, diabetes, allergies, etc

Relationship	Age (if deceased, age at death)	Health issue
Mother		
Father		
Siblings		
Grandmothers		
Grandfathers		

Vaccinations

Type	When / how old

Allergies

Type	When / how old
Any medications? (e.g. penicillin)	
Any foods?	
Any supplements?	
Any chemicals?	
Environmental e.g. pollens, pesticides, moulds?	
Sinus / hay fever?	
Eczema as infant? Currently?	
Other?	

Infant nutrition

Breast-fed	**Yes, how long for?**	**No. Why not?**

Birth	**Vaginal**	**Caesarean**

Has the child been exposed to toxic chemicals, cigarette smoke, solvents, sprays, pesticides, herbicides, heavy metals or mould? Provide details

_____

_____

_____

Sleep habits

_____

_____

_____

Current weight _____ & height _____

Are there any foods that the child craves? If so, please explain

_____

Which foods the child avoids and why? _____

_____

<u>What percentage of the meals is home-cooked?</u>

☐ 10-20 ☐ 30-40 ☐ 50 ☐ 60-70 ☐ 80-90 ☐ 100

Please provide any other information you think would be helpful to address your health concerns.