



sam adkins
homeopathy

child health history

PATIENT DETAILS

Child's Name: _____ DOB _____ Age _____ Sex _____

Parents' Names _____

Address _____

Email _____

Phones: _____ H _____ W _____ M _____

GP _____

Name _____ Phone _____

Address _____

MAIN HEALTH ISSUE

What problem would you like treated (please describe)

List your child's current symptoms and any factors which make them better/worse (activity/rest/foods/temperature/weather etc)

Symptom _____ Modifying factor _____

When did this problem start? (Include here any events that preceded it such as moving house, after an illness.)

Please list all conventional and complementary medical treatments you have tried so far for this issue. Please rate them on a scale of 1 (low efficacy) - 5 (high efficacy)

Additional health Issues

What medications/supplements/herbs is your child currently taking?



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PATIENT GENERAL HEALTH INFORMATION

Does your child have? Please rate all of the following on a 1-5 scale (1 is low severity and 5 is high severity)

Allergies/sensitivities to Drugs (eg penicillin)

Foods

Environmental(eg pollens or dust)

DIGESTIVE SYMPTOMS

Tummy Pain

Bloating

Indigestion

Diarrhoea

Constipation

Wind/burping

itchy bottom/nose

How often does your child have a bowel motion?

Does your child have any food cravings?

Are there any foods which disagree with your child?

SLEEP PROBLEMS

Difficulty getting to sleep

Waking during sleep

What time?

How is your child on waking?

SYMPTOMS IN OTHER AREAS? (Please circle anything current)

Head / Eyes / ears / nose / teeth / chest / urinary tract / menstrual / reproductive / skin / skeletal

Does your child have any of the following currently or in the past (please circle) Eczema / asthma / hayfever

BODY TEMPERATURE

Would you describe your child's body temperature as (please circle)

Average / warmer than normal / cooler than normal

Are your child's hands/feet usually (please circle)

hot / cold / sweaty / clammy

ENERGY LEVELS ON SCALE OF 1-10 (with 1 being low and 10 being very high) 1 2 3 4 5 6 7 8 9 10

MORE ABOUT YOUR CHILD

Fears or phobias

Is your child anxious? please describe:



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Describe your child's usual temperament

Please outline here any emotional/behavioural problems your child may be experiencing

YOUR CHILD'S MEDICAL HISTORY

The mother's health during pregnancy?

Did your child experience any birth trauma?

Breastfed? Yes/no

How long?

Any medications given to mother/child during pregnancy/labour/birth?

Did your child have any vaccination reactions? (Please bring your child's blue book to the consultation)

Recurring infections? Yes/no

Where?

Approx number of courses of antibiotics taken in total?

PLEASE GIVE DETAILS OF ANY ADDITIONAL HEALTH ISSUES YOUR CHILD HAS HAD (including operations, viruses, injuries)

0-5

5-10

10-15

FAMILY MEDICAL HISTORY

Please list known diseases of family members (skin problems, heart disease, high blood pressure, cancer, diabetes, mental illness, other)

Mother

Father

Close Family

DESIRED OUTCOME FOR YOUR CHILD'S TREATMENT?

ANYTHING ELSE YOU WANT ME TO KNOW? (Use this space to tell me things you do not want to say in front of your child)
