

Child History Record

KARUNA HEALTH CARE
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Allow 20 minutes to complete this form 3 pages)

Date: _____

Child's name _____ Age _____ Sex _____ DOB _____

Parents' names: Mother _____ Father _____

Address _____ Post Code _____

Phone: H: _____ W: _____ Mob _____

Email _____ Health Fund _____

GP's name, address and contact number: _____

Specialist's name, address and contact number: _____

* For distance consultations, please indicate how we are able to contact you:
 Email Telephone Fax (.....)..... Skype user name.....

Please complete the following pages in as much detail as you can. Providing detailed information makes it easier to accurately assess your child's health status - no detail is too small!

What would you like to have your child treated for? List complaints in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

Please list symptoms, in order of severity. (First symptom the most severe)

How and when did the symptoms start?

Are there any other health problems? If yes, please list:

What medical treatment(s) has your child had so far?

What natural therapies have you used so far?

Which of these treatments have you found to be the most effective?

.....

Please list **current** prescribed medications

.....

.....

Please list current supplements - vitamins, minerals, herbs etc

.....

.....

.....

Any previous homeopathic medicines? Please list.....

.....

General information.

Please rate your child's energy levels (circle) [No energy] 0 1 2 3 4 5 6 7 8 9 10 [high energy]

Symptoms during sleep? *Please circle:*

Snoring, mouth breathing restlessness, sleepwalking, night sweats, perspiration, nightmares

Any other symptoms during sleep?

Regular wakefulness? Time of waking? Reason for waking?

What **position** does your child usually sleep in?

How is your child in the morning on waking?

Are there any drug, environmental, food, or other allergies?

How does your child tolerate hot weather? Cold weather?

Digestion: please circle

Is there: tummy pain, bloating, burping, diarrhoea, constipation, mushy stools, wind?

Before, during or after eating?

Please describe the frequency, texture and odour of bowel motions.....

What are your child's favourite foods?

Which foods does your child really dislike?

Which, if any, foods cause symptoms?

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Mental/Emotional

Are there any anxieties, fears or phobias? (eg heights, spiders, tunnels, crowds, snakes, the dark, shyness, thunderstorms)

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Medical History

An accurate, sequential time line of your child's medical history is important. Please include all traumas (include any that surrounded your child's birth), stressful events, surgeries, hospitalisations and courses of antibiotics.

0 - 1 yrs:

.....

1 -2 yrs:

.....

2 - 3 yrs.....

.....

4 - 5 yrs.....

.....

5 - 6 yrs.....

.....

6 - 7 yrs.....

.....

7 - 8 yrs.....

.....

8 -9 yrs.....

.....

10 + years

.....

Family History

Please describe **all known diseases** of the following family members eg heart disease; high blood pressure; diabetes; cancer; skin problems (eg psoriasis); TB; allergies; mental illness; alcoholism

Mother

Father

Immediate family (brothers, sisters, grandparents, aunts and uncles;
.....

Please list medical tests you have had, *in chronological order*:

TYPE OF TEST	DATE	REASON	RESULT
<input type="checkbox"/> Blood test(s)			
<input type="checkbox"/> X Ray(s)			
<input type="checkbox"/> CT scan			
<input type="checkbox"/> Ultrasound			
<input type="checkbox"/> Hearing test			
<input type="checkbox"/> Other			

Anything else you would like to mention?

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Where did you hear about this clinic?

- Word of Mouth Advertisement Brochure Yellow pages book Yellow Pages online
- Natural Therapy Pages Personal Internet search Other

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