

What natural therapies have you used so far?

[Redacted]

Current supplements – vitamins, minerals etc?

[Redacted]

Current prescribed medications?

[Redacted]

■

[Redacted]

General health & lifestyle 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?

snoring mouth breathing restlessness sleepwalking
night sweats perspiration nightmares

Any other symptoms during sleep? [Redacted]

Regular wakefulness? [Redacted] Time of waking? [Redacted]

Reason for waking? [Redacted]

What position does your child like to sleep in? [Redacted]

How is your child in the morning on waking? [Redacted]

Does your child have any drug, environmental, food, or other allergies? Please state:

[Redacted]

How does your child tolerate hot weather? [Redacted] Cold weather? [Redacted]

Digestion: Is there?

Tummy Pain Wind Bloating Mushy Stools Constipation
Diarrhoea Burping

When does your child get these symptoms in relation to eating? Before, during or afterwards?

[Redacted]

Please describe the frequency, texture and odour of bowel motions

[Redacted]

What are your child's favourite foods? [Redacted]

Which foods does your child really dislike? [Redacted]

Which, if any, foods cause symptoms? [Redacted]

Are there any fears of phobias? (e.g. heights, spiders, tunnels, crowds, snakes, the dark, thunderstorms)

Medical History

An accurate timeline of your child's medical history is important. Please include all traumas (including around your child's birth), stressful events, surgeries, hospitalisations, and courses of antibiotics.

0-1 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
1-2 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
2-3 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
3-4 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
4-5 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
5-6 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
7-8 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
8-9 yrs:	<div style="background-color: #e6f2ff; height: 38px;"></div>
10+ years:	<div style="background-color: #e6f2ff; height: 38px;"></div>

Family History

Please describe all known diseases of family members e.g. heart disease, high blood pressure, diabetes, cancer, skin problems (e.g. psoriasis), TB, allergies, mental illness, alcoholism.

Mother

Father

Immediate family (brothers, sisters, grandparents, aunts and uncles)

Please list medical tests you have had

TYPE OF TEST	DATE	REASON	RESULT
Blood Test(s)			
X Ray(s)			
CT Scan			
Ultrasound			
Hearing Test			
Other			

Anything else you would like to mention?

BEFORE COMING TO CLINIC:

- If you would like to know your health fund rebate amount, please check with your fund prior to the consultation.

Where did you hear about the clinic?

PARENTS

I agree to the Terms and Conditions, found in the **Policies** section on the Booking page at <https://karunahealthcare.com.au/book-appointment/>

KARUNA HEALTH CARE