NATURAL PRACTICES

Children's Health Questionnaire

Name of child _____
Date of birth _____ Age _____
Address _____
Postcode _____

GP name and address _____

Parent/ guardian name: _____
Parent/ guardian mobile number: _____
Parent/guardian email address:
_____
(This is to receive your child's report)
Main reason for today's visit _____

Please tick your symtoms **Occasionally** ☑ (every six months)
Frequently ☑☑ (more than once a month)

Child suffers from:

General
Headaches Fever ☐☐
Dizziness ☐☐
Convulsions/ fits ☐☐
Loss of sleep ☐☐
Allergies (**please list known allergens**) ☐☐
_____
Hives ☐☐
Hayfever ☐☐
Wheezing ☐☐
Thirst ☐☐

Ear, nose, throat
Deafness ☐☐
Earaches ☐☐
Ear noises ☐☐
Ear discharge/infections ☐☐
Nose bleeds ☐☐
Blocked nose ☐☐
Frequent colds ☐☐
Sore throat ☑☐
Tonsillitis ☐☐
Enlarged glands ☐☐

Skin/lungs
Asthma ☐☐
Spitting up phlegm ☐☐
Chronic cough ☐☐
Skin eruptions ☐☐
Itching skin ☐☐
Eczema weeping dry alternating ☐☐

Muscular/ joints
Backache ☐☐
Stiffness or muscular spasm ☐☐
Foot trouble ☐☐
Weak joints? Which ones _____
Swollen joints? Which ones _____
Tremors ☐☐

Genito-urinary
Bed-wetting ☐☐
Frequent urination ☐☐
Wears nappies ☐☐

Gastro-intestinal
Poor appetite ☐☐
Excessive hunger ☐☐
Burps a lot ☐☐
Complains of bad taste? Y/N ☐☐
Trumps a lot ☐☐
Smelly? Y/N ☐☐
Complains of feeling sick ☐☐
Reflux ☐☐
Vomiting ☐☐
Heartburn/indigestion ☐☐
Tummy aches ☐☐
Constipation ☐☐
Diarrhoea ☐☐
Intestinal worms now or in past? Y/N ☐☐
Jaundice at birth or since Y/N ☐☐
Colitis ☐☐
Crohn's disease ☐☐
Coeliac disease ☐☐

Birth

Did mum have any illnesses during pregnancy Y/N☐☐
please list _____
Vaginal birth no complications Y/N☐☐
Caesarean section Y/N☐☐
Forceps/Ventouse delivery? Y/N☐☐
Complications after birth? Please state:
_____
Breast-fed? Y/N☐☐
until what age? _____
Supplemented with formula whilst
breast-feeding Y/N☐☐
Bottle-fed from birth? Y/N☐☐
Colicky baby? Y/N☐☐
Difficulty sleeping in first year? Y/N☐☐
Usual childhood vaccinations? Y/N☐☐
Any noticeable reactions? Y/N☐☐
How many courses of antibiotics have been taken
in child's lifetime? _____
How many general anaesthetics needed? _____

Operations:

Please list any organs removed or operations undertaken
_____
Please list any investigative procedures
(x-ray, brain scan, colonoscopy etc)
_____
Please list any Diagnoses
(diabetic, epileptic, autistic, coeliac etc)
_____
Current medications:
_____
_____
_____
Current natural supplements
_____
_____
_____
_____
_____
_____

Parent:

I agree to my child _____ having a Health Screening and understand this is not a diagnostic technique but that it merely looks at imbalances in the body. Any health advice suggested is not intended to replace the advice of your GP or Consultant and any suggested changes to diet or intended use of herbs or nutritional supplements should first be discussed with them.

Parent/ guardian name (printed) _____

Parent/ guardian signature _____

Date: _____