



## Child Medical Questionnaire

**Please complete all the white boxes and bring the completed form and your child's Developmental Book to the initial consultation.**

Date of first appointment (dd/mm/yyyy)

**Child's details:**

Child's first name

Child's last name

Male  Female

Date of birth (dd/mm/yyyy)

Height (centimetres)

Weight (kilograms)

Address

Post code

**Parent's/Guardian's details:**

First name

Last name

Contact number

Alternative

Child's GP name

GP address

GP contact number

**Child's condition:**

Does your child have immune deficiencies?

Yes  No

Please describe your child's main symptom(s).

Please describe any other known conditions.

**Child's environment and diet details:**

Yes No

Does your child live in the country?

 

Does your child live near a main road?

Yes No

 

Are there any smokers in the household?

Yes No

 

Is there gas in the home?

 

Are there coal fires in the home?

 

Does your child eat regularly?

 

How many times per day does your child eat?

Was your child bottle fed?

 

Does your child have a poor appetite?

 

→ If yes, please describe.

Is there any food that your child eats at least once a day or craves?

 

→ If yes, please list.

Is there any food that makes your child ill?

 

→ If yes, please list.

Is there any food that you avoid giving your child because it disagrees with him/her?

 

→ If yes, please list.

**Please tick the following that apply to your child and/or anyone in the child's immediate biological family:**

|                                  | Your Child               | Child's family           |                    | Your Child               | Child's family           |
|----------------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| Asperger Syndrome                | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema                           | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis          | <input type="checkbox"/> | <input type="checkbox"/> |
| Crohn's Disease                  | <input type="checkbox"/> | <input type="checkbox"/> | Lupus              | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                         | <input type="checkbox"/> | <input type="checkbox"/> | Pernicious anaemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                           | <input type="checkbox"/> | <input type="checkbox"/> | Addison's disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart problems                   | <input type="checkbox"/> | <input type="checkbox"/> | Autism             | <input type="checkbox"/> | <input type="checkbox"/> |
| Other illness (please describe): |                          |                          |                    |                          |                          |

**Please enter the appropriate value for each of the following symptoms using the following point system:**

- 0 = Never/almost never has the symptom
- 1 = Occasionally has it, effect is not severe
- 2 = Occasionally has it, effect is severe
- 3 = Frequently has it, effect is not severe
- 4 = Frequently has it, effect is severe

|                                   | Points:              |  | Points:                            |
|-----------------------------------|----------------------|--|------------------------------------|
| Wheezing / Coughing               | <input type="text"/> | Bedwetting / soiling (if toilet trained) | <input type="text"/>               |
| Running nose                      | <input type="text"/> | Incontinence                             | <input type="text"/>               |
| Catarrh                           | <input type="text"/> | Frequent urination                       | <input type="text"/>               |
| Sneezing                          | <input type="text"/> | Pain on passing urine                    | <input type="text"/>               |
| Sniffing                          | <input type="text"/> | Excessive thirst                         | <input type="text"/>               |
| Recurrent earache                 | <input type="text"/> |  | <b>Total:</b> <input type="text"/> |
| Frequent throat infections        | <input type="text"/> | Mouth ulcers                             | <input type="text"/>               |
| Nasal "crease" (line across nose) | <input type="text"/> | Coated tongue                            | <input type="text"/>               |
| Nose rubbing                      | <input type="text"/> | Patchy, sore tongue                      | <input type="text"/>               |
| Itching inside the ears           | <input type="text"/> | Bad breath                               | <input type="text"/>               |
| <b>Total:</b>                     | <input type="text"/> | Hiccups                                  | <input type="text"/>               |
| Skin rashes                       | <input type="text"/> | Abdominal pain                           | <input type="text"/>               |
| Skin itching                      | <input type="text"/> | Abdominal bloating                       | <input type="text"/>               |
| Dry skin                          | <input type="text"/> | Diarrhoea                                | <input type="text"/>               |
| Skin infections                   | <input type="text"/> | Constipation                             | <input type="text"/>               |
| <b>Total:</b>                     | <input type="text"/> |  | <b>Total:</b> <input type="text"/> |
| Hyperactivity                     | <input type="text"/> | Dark circles beneath the eyes            | <input type="text"/>               |
| Tantrums                          | <input type="text"/> | Abnormal "milestones"                    | <input type="text"/>               |
| Mood swings                       | <input type="text"/> | Unexplained crying                       | <input type="text"/>               |
| Abnormal sleep pattern            | <input type="text"/> | Aching legs                              | <input type="text"/>               |
| Night terrors                     | <input type="text"/> | Joint pain / swelling                    | <input type="text"/>               |
| Poor concentration                | <input type="text"/> | Low weight                               | <input type="text"/>               |
| Headaches                         | <input type="text"/> | Abnormal weight                          | <input type="text"/>               |
| Talkativeness                     | <input type="text"/> | Redness of the ears                      | <input type="text"/>               |
| Sudden sleeping                   | <input type="text"/> | Puffiness around the eyes                | <input type="text"/>               |
| <b>Total:</b>                     | <input type="text"/> |  | <b>Total:</b> <input type="text"/> |

**Grand Total**