CHILDREN'S HEALTH QUESTIONNAIRE

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CHILD'S NAME : Your Name :	Today's date : School Grade: Birth date: Child's Age :	How did you hear about us? *(If someone referred you, who was it?)*
ADDRESS : Postcode :	Your Phone # : Mobile Home Work EMAIL address	Height: Weight: Ideal Weight:
Your Occupation: / Partner's Occupation:	Do you have other children? (names, ages, health issues) :	

What is the main reason for your visit? (Please be specific and detailed, include the history of the issue and what has been done about it so far.) Are there any secondary issues that you would like to mention?	**Rate your child's general Overall Health /** Wellness / Resiliency out 10, where 10 is excellent.	
	Rate your child's **general state of Stress / Anxiety** out 10, where 10 is high.	
	Rate your child's **general Immunity / Immune Resilience**, where 10 is excellent.	
	Does your child have a contagious infection at present? ***Please let us know before your appointment if they do.***	

Please outline your child's health history (Past issues, including approximate age – include infections (tonsilitis, roseola, chicken pox, rashes, strep throat, vaccines, medications, etc.)	Are there any hereditary diseases or disorders in the family? (eg: hypercholesterolemia, diabetes, cancer, hypothyroidism, pernicious anaemia, Thrombosis, Hemochromatosis, Thalassemia, Leukaemia, Thrombocytopenia, Sickle Cell Anaemia / Trait etc.)
Are they presently taking any **supplements**?	Is you child currently taking **medication**, if so what for? What medications do they take ***occasionally*** and what are they for?
SLEEP – Do they sleep well? **Rate the quality : /10** (ie: 0=not sleeping; 10=go to sleep easily, sleep through the night, wake refreshed)	**ENERGY –** How would you rate their general level of energy? (where 10 is excellent) **/10**
Total number of courses have had in their lifetime? Antibiotics / Penicillin Vaccinations Painkillers (including Panodol) Steroidal anti-inflammatories (like inhalers / skin creams) Anaesthetics **Other**	Has your child ever been bitten by a tick? Have they suffered any trauma, grief, violence, major accidents, surgery, acute or chronic pain? If yes, please give details.

Do they have any **Allergies**, **Intolerances** or **Sensitivities** to anything that you know of?
(ie: foods, lactose, casein, wheat, gluten, dust, medications or other substances)

Connor's Global Index

Rate for the last month.	Never / Seldom	Occasionally	Often / Quite a bit	Very often / frequently
1. Restlesness or overactivity				
2. Excitable, impulsive				
3. Fails to finish things started				
4. Inattentive, easily distracted				
5. Temper outbursts				
6. Fidgeting, jiggling				
7. Disruptive to other children				
8. Demands must be met immediately or easily frustrated				
9. Cries easily or often				
10. Mood changes quickly or drastically				
Tally				
Total out of 30				

Body Systems:

	If yes, please give details :
Has your child ever been bitten by a tick? Has their mother?	
DIGESTION? ie : bloating, indigestion, ulcers, poor digestion, poor sense of taste, metallic / bad taste in mouth, bleeding gums, sores at corners of lips etc. Other :	
BOWEL? (ie: constipation, loose stools, bowel urgency, odour, flatulence, undigested food in stools, colitis, Irritable Bowel Syndrome etc. • Have they ever visited a country where they've possibly picked up a gut bug? (ie: bali belly) • Have they had any gastrointestinal infections requiring antibiotics or other treatment? **If Yes, What?**	**Type of stools** (delete those not applicable) : poorly formed / bitty / narrow, thin & unformed / mucous containing / light coloured / dark coloured / floating / odorous / hard & dry / sticky or messy / difficult to pass / an event(!) / well formed & easy to pass Other :
URINATION? scant urination, strong smelling or dark yellow urine, urinary tract infections, burning/ pain, kidney problems etc.	
CIRCULATION SYSTEM? ie : anaemia, easy bruising or bleeding, ringing in ears, surface veins, racing pulse, irregular heart beat, dizziness, cold feet, heart valve issues, general weakness of the heart?	
NERVOUS SYSTEM? (ie: headaches, migraines, numbness / tingling, epilepsy, easily stressed, over-sensitive etc.)	
TEMPERAMENT – describe your child's personality, their strengths, weaknesses, and what sorts of things throw them out or destabilise them.	
MOOD / EMOTIONS / BEHAVIOUR? Eg: anxious, depressed, tends to ADD, ADHD, Aspergers. Melancholic, down, sad, aggressive, irritable, angry, agitated, withdrawn, oppositional; lonely, lost, restless, easily agitated, frustrated, addictive nature; OCD, obsessive, compulsive; happy, easy going, loving, calm, etc.	
HORMONES? (ie: hormonal problems, hypo / hyper thyroid, growth problems, adrenal problems, early puberty, undescended testes etc.)	
BONES / MUSCLES? (ie : bone breaks or fractures, rickets, bow legs, pigeon toes, cavities, muscle pain / strain, cramps etc)	
SKIN – eczema, dermatitis, rashes, psoriasis, itching, urticaria, blotchiness, fair skinned, nappy rash etc.	
IMMUNE / RESPIRATORY SYSTEM? (ie: frequent colds, sore throats, runny nose, hayfever, sinusitis, asthma, ear infections, history of bronchitis / pneumonia / glandular fever etc?) **Have they had (circle or delete those not applicable) :** chicken pox, mumps. measles, slap cheek, hand-foot-mouth, roseola, high temperatures, whooping cough, bronchitis, bronchiolitis, tonsillitis, ear infections, Staph infection , perforated ear drum, fluid on the ear? Other :	
FEVER – do they mount a fever easily if they get sick? How do you manage temperatures / fevers / colds? Do you let them have a temp?	
TEMPERATURE – are they a HOT OR COLD body type? Are they better form warm rooms or cool rooms, do they tend to feel hot or cold generally, do they like to be uncovered or covered up?	

Vaccination History:

What vaccinations have they had & at what age/s?

• Vitamin K – routinely given at birth unless otherwise specified • Hepatitis B (circle): at birth – 2mths – 4mths – 6mths or 12mths • Diphtheria-Tetanus-Whooping Cough (circle) : 2mths – 4mths – 6mths • Hib type b (circle): 2mths – 4mths – 6mths - 12mths • Polio (circle): 2mths – 4mths – 6mths - 12mths (oral / injection?) • Pneumococcal disease (circle): 2mths – 4mths – 6mths • Measles-Mumps-Rubella (circle): 12mths – 4yrs • Meningococcal C disease : 12mths – 4yrs • Chickenpox : 18mths	Any other vaccinations?	Did you notice any change/s in your child after vaccination?

INTRODUCTION OF SOLIDS – at what age did your child start solids? At what age did they start having : wheat (bread, pasta, cereal, crackers, biscuits etc) dairy – yogurt, milk by the glass, cheddar cheese eggs chocolate sweets / sugar juice nuts - what kind?	Are there any food sensitivities that you suspect yourself? (ie: foods they don't tolerate well)

Diet & Lifestyle

Do you follow a special diet (vegetarian, vegan, gluten free, dairy free, pescatarian, paleo etc)

Please give an example of typical day's food and drink intake:

BREAKFAST	LUNCH	SNACKS & DRINKS	DINNER

ARTIFICIAL SWEETENERS : What 'SUGAR FREE' FOODS / DRINKS does/has your child have/had? (900 numbers – please check the labels of the foods in your pantry or fridge before you answer this question)

Sugar-free cordial / Soft drink / Juices / Jelly / yogurt / Extra gum / Chewing gum / Sweets / Mints / Icecream

Other :

DIET : Drinks (circle) - Water - How much per day?
Juice What & how much?
Milk by the glass
Cordial
Soft drink – What & how much?
Tea / Coffee / Herbal Tea How much per week?
Sweets / Lollies / Chocolate? Y / N How much / what, how often?
Cake / Biscuits How much per week?
Chips / crisps? How much per week?
Do you / they spoon sugar onto food (ie: cereal) or into drinks? How much, what, how often?
How much sugar would your child have in a day? (describe sources and guesstimate how many teaspoons it would contain)
(1 teaspoon = 5g of sugar)
What are your child's biggest dietary weaknesses?

How many serves of dairy would your child have in a day?
What do they have?
Milk (full / low fat / formula?)
Yogurt – what brand & how much /day?
Cheese – type/s, brand, how much?
Ice cream - brand, flavour, quantity?
Yogo / Custard - brand, flavour, quantity?
Fruche
Dairy Rice dessert
Other -
How many serves of protein would your child have a week :
For example : Eggs Beef Lamb Chicken Fish
Nuts – Almonds / Brazils / Pecans / Hazelnuts / Macadamias / Peanuts / Cashews / Other : - Salted
What type and how much bread do they eat?
What spreads / sandwich fillings do they have? (Nutella / Vegemite / Peanut Butter /jam….)

Environment

Do you have wireless internet? Do you switch it off at night?	
Does your child have a digital clock by their bed?	
Which room in the house does the power box / smart meter connect to your home?	
Do any of the rooms have visible mould on the walls / tiles / ceiling?	
Does your home smell damp or mouldy? (Can help to ask a person who doesn't live there.)	

Habits, Behaviours, Tendencies

What are their favourite things to do? Do they have any ADDICTIONS or addictive behaviours?	
How are they at SELF-REGULATING – can they manage their emotions well, or do they fly off the handle easily? Are they generally calm or do they emotionally dysregulate easily?	
Are they SOCIAL / more EXTROVERTED, or WITHDRAWN / INTROVERTED generally?	
Do they have lots of friends, tend to keep to one close friend or are they a loner?	
Are they resilient or sensitive in nature?	
How much full body sunshine does your child get in a week without wearing sunscreen or a rashie?	
Does your child have any behaviours that seem unusual?	
SCHOOL - How are they doing at school?	
How are they at ENGLISH and handwriting?	
How are they at MATHS and sums?	

SPORTS – are the sporty or not so sporty? What sports do they play?	
SCREENS - How much time per week does your child spend on an ipad / iphone / ipod / computer / other digital media? What times of the day do they tend to go on – how often, how long?	
EVENINGS - Do they wind down in the evenings and go to bed easily, or do they tend to wind up, increase in restlessness with the evening and struggle to go to bed?	
Is there anything else that you'd like to note?	

Just a few questions about you and this child's birth :

YOUR PREGNANCY – How was your pregnancy with this child? Easy / Mildly to moderately troublesome / Difficult

LABOUR : How long was your labour in total?
Did you labour stall at any stage? What was done about it?
Were you induced? If yes, at how & at how many weeks?

Did you have (HIGHLIGHT)*:*
Vacuum extraction Caesarean –Emergency / Elective; with Full or Partial anaesthetic
Epidural Pethidine Gas (Nitrous oxide) Water Birth Episiotomy Natural tear

Syntocinon to deliver the placenta?
Did you **haemorrhage** or lose a lot of blood?

Did the baby receive Vitamin K injection ?
Hepatitis B vaccine?
Any other medications directly or indirectly?

Did you or the baby have any illnesses in the year after birth?
Whooping cough / bronchiolitis / measles / mumps / chicken pox / gastritis / girardia / pneumonia / other :

Do/did you have any signs of post natal depression?

Please describe your **birth experience**.

How do you feel mentally & emotionally at present?

Are you okay?

Rate YOUR energy out of 10 where 10 is excellent : / 10

Rate your sleep out of 10 where 10 is restful and energising : / 10

What time do you go to bed? What time do you rise & how often are you up in the night?

Rate your HEALTH out of 10 where 10 is great:

Did you have any **vaccinations or medications** during your pregnancy or in the twelve months prior to conception? (include vaccines, medications, antibiotics, procedures, etc) - **how many weeks pregnant were you at the time?**

ULTRASOUNDS – how many and at what stages?

AMNIOCENTESIS –

XRAY (dental or otherwise) -

FLU VACCINE –

WHOOPING COUGH VACCINE –

COVID VACCINE -

STEROIDS –

ANTIBOTICS –

ANTI-NAUSEA MEDICATIONS –

PANODOL / NEUROFEN / PAIN RELIEF –

ALCOHOL –

CIGARETTES –

SUGAR ++ -

CAFFEINE -

RECREATIONAL DRUGS -

Have you used any other medications before or during your pregnancy and lactation period (Including contraception)? List the date/s started and/or stopped:

PRENATAL AND PREGNANCY TESTING – were you diagnosed with anything during your pregnancy? (eg: trisomy gene, anaemia, anxiety, depression, pelvic instability, placenta previa, hypertension etc)

HOW ARE YOU FEELING ABOUT MOTHERHOOD?

HOW DO YOU MANAGE STRESS OR EMOTIONAL STRAIN?

WHAT DO YOU DO TO CARE FOR YOURSELF?

WHAT SUPPORT DO YOU HAVE?

HOW IS YOUR HEALTH?

Are there any other issues that you'd like to include?

DECLARATION

I understand that this is an integrated holistic healthcare clinic, not a mainstream or medical clinic**, we do not diagnose disease, allergies or other medical conditions, nor do we prescribe or advise people on scheduled pharmaceutical drugs.** If we discuss aspects of your mainstream medical care, please do not take our conversation as diagnostic, prescriptive or directive in the medical sense. Our role is to simply help you find your way to a healthier body, lifestyle and outlook.

Throughout your work with us, we may discuss the use of Nutrition, Herbs, Dietary Measures, Homeopathic/resonance Remedies, Supplements. These things may interact with some medications that you MAY start or stop, so keep your practitioner in the loop.

As part of our integrative approach, we may use techniques such as counselling, coaching, up-time hypnotherapy methods, Neurolingusitic

It is important to understand that when the obstacles to the body's own self-healing processes are removed, healing happens. The body heals itself, we are simply here to remove the obstacles and support the self-healing prcess. All healing is self-healing.

It is important that in all things you remain 100% responsible for your decisions, actions, and choices, and your application of any tools and insights you may receive during your session. If you have any questions, please discuss these with your practitioner directly. Each session offers part of a whole process, it is important to attend regular appointments so the next part can be brought in as you progress. We don't want you to stay on things for months and months without a check-in. As things change we want to respond and adapt. Don't stop before your program is complete.

In attending your appointment you certify that the above and all information given in session is true, accurate and correct. Should anything change in anyway, please notify your practitioner, as it may affect what we are doing.

Please sign to confirm that you have read and understand these points, and the above information is accurate and correct:

Name:	Signed :	Date :

All information including pricing, cancellation policy and privacy policy is on our website. This changes regularly so be sure to review them.