

STRICTLY CONFIDENTIAL
HEALTH QUESTIONNAIRE FOR HOMEOPATHIC TREATMENT (CHILD)



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First Name:		Gender:	MALE / FEMALE
Middle Name(s):		Age:	
Surname:		Date of Birth:	
Name of Mother:		Birth - WEIGHT:	
Occupation:		Current - WEIGHT:	
Name of Father:		Current - HEIGHT:	
Occupation:			
Unmarried / Married / Separated / Divorced / Widowed			

PLEASE READ THROUGH ENTIRE QUESTIONNAIRE BEFORE ANSWERING!

When answering, please note that it is in your best interests to give as much detail as possible, the more accurate and complete the information given the better I am able to help you.

Please describe pains as fully as possible, using words such as:

sharp, dull, jerking, boring, tearing, burning, bursting, pulsating, constricting, cramping, numb, numb yet with pain, cold, etc...

If pain moves from one part to another - name the parts/describe. Give the sensations in your own language no matter how simple, or even ludicrous. State what makes the pain *better* or *worse* - such as:

pressure, movement, rest, seated, standing, walking, heat, cold, food, sea-air, coition, time of day, time of year, bathing, taking a very hot shower, etc...

AS FAR AS POSSIBLE, PLEASE GIVE YOUR OWN UNIQUE *DESCRIPTION* IN YOUR REPLY, THE IMPORTANCE OF THE INFORMATION YOU GIVE IS IN THE *INDIVIDUALITY* OF YOURSELF AND NOT JUST A YES OR NO ANSWER.

	ANSWER
1 Colour of Eyes?	
Hair:	
Complexion:	

2	Describe your <u>MAIN COMPLAINT(S)</u>:	
<p>When did it begin? What happened in the child's life around that time? What makes it better or worse? When is it better or worse, specify hour if you can? What do you think caused it? What other symptoms may accompany this main complaint?</p>		

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3	HEAD: Describe pains and give their location - on top, back, front or side, etc.	
4	EYES: Describe pain, defect of vision, defect of eye or any troubles, etc.	
5	NOSE: Describe catarrh, colour, watery, thick, plugs, burning, sneezing, allergies, any sinus pain / blockage, etc.	
6	EARS: Describe pains, deafness, noises, itching, discharge, etc.	
7	MOUTH: Describe condition of teeth, colour of tongue, peculiar taste? Tonsils/Lips, DESCRIBE: Are you thirsty? Do you crave anything to drink? What? What temperature do you like it? e.g. ice cold How much cold liquid per day do you drink? How much hot liquid per day do you drink?	How much sugar per cup?
8	THROAT: Any difficulty swallowing, pain, on left or right side, better or worse when swallowing liquids / food?	
9	CHEST: Describe pain, palpitation, breathlessness, sensations, cough, sputum, need for open windows, asthma? What make it better / worse? Any change through the day / night?	
10	STOMACH: Describe pains, nausea, vomiting, flatulence, etc... Foods you crave: Foods that disagree: Are symptoms better/worse after eating? How long after?	
11	DIET: Please describe you last 24 hours meals in detail. (What, how much, how it was prepared, etc.)	
	Breakfast:	
	Snack:	
	Lunch:	
	Snack:	
	Dinner:	
12	STOOLS: How frequently do you pass a stool? Describe if: hard/watery/mixed with blood/mucus/fat/undigested food, etc. colour, unusual smell? Describe constipation / laxatives use... Do piles bleed or protrude? Any discharge? Is there pain/itch, skin raw, inflamed?	

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13	URINE: If painful, burning, frequent, involuntary/difficult. If there is pressure, sediment, odour, retention - give colour. Do you go at night? What time/s?	
14	GENITALIA: Describe any pain, itch, discharge, swelling, skin eruptions etc. History of illness in this area: Female: Has menstruation begun? When? Describe?	
15	BACK: Position of pain in shoulder, back, waist, seat or spine, better or worse for...?	
16	LIMBS: If pain, is it in: muscle, nerve, joint or skin & exact location – better/worse for movement/rubbing / weather changes etc.	
17	SKIN: If rough, itching, burning, dry or moist. Describe any strange sensations, eruption, rashes, inflammation, odour, sloughing State parts affected.	
18	PERSPIRATION: Do you - at all? If so, where do you start perspiring from? And when exactly? Does it smell? A lot? Does it discolour clothing? What colour?	
19	GENERAL: Do you feel better: Indoors or outdoors? In cool air or a warm room? When resting or moving about? At night or during the day? Time? In Summer/Autumn/Winter/Spring? When hot/cold? Wet/dry weather? At the seaside or inland/mountains? Describe your weekly physical exercise.	
20	SLEEP: If restless, disturbed. When you waken - what time/s? What wakens you? Is it pain, worry, emotion, excitement, dreams? Are your troubles better or worse at night? What position do you sleep in? What do you dream about?	

21 | **MENTAL SYMPTOMS:** *The symptoms of the Mind and Disposition **ARE MOST IMPORTANT** and should be carefully considered and reported. Give this section your particular thought.*

How would you describe your child?	
Describe hopes, dreams, desires and fears :	
What does your child spend most of your time thinking/talking about? (And/or favourite activity)	
What is the most important aspect of your child's life and why?	
Describe 5 positive characteristics AND 5 negative characteristics about your child:	
If your child could change one thing about themselves what would that be and why?	
What traits does your child like the least in others ?	
Are there any observations that others close to your child have commented on about them?	
How would you describe your child's emotional state?	
What is your religious belief?	
What role does this play in your life?	

22 | **Biography of your life:** (give a description of the important/significant/recurrent events in your life since birth to date.)

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23	Have you suffered from any of the following?				
Rheumatic fevers		Scarlet fevers		Glandular fever	
Typhoid		Cholera		Bilharzias	
Malaria OR prophylaxis		Mumps		Tumours / Cancer	
Diabetes		Measles		Whooping Cough	
Bronchitis		Pneumonia		Heart Disease	
Sinusitis		Hepatitis		Yellow Jaundice	
X-ray, MRI, CT or Radium/Cobalt Treatments?					
When last were you immunized?					
List all immunization received?					
Do you smoke? For how long and how many?					
Do you drink Alcohol? How much and for how long?					
Describe any operations &/or accidents.					
Is your food cooked in aluminium pots?					
List & date all destinations travelled to recently & in the past: (Outside the Western Cape)					

24	<u>ALL CURRENT MEDICATION & SUPPLEMENTS:</u> <i>Please list full name and dosage:</i>

25	<u>Family Medical & Social History:</u> (Please also include any major family problems/issues)
Mother:	
Mother's Mother:	
Mother's Father:	
Father:	
Father's Mother:	
Father's Father:	

26	<u>Mother's PREGANANCY with you:</u>
What was your predominant emotional state when pregnant with this child?	
During the pregnancy, did you suffer any particular shocks or traumas or losses?	
Did you take any medicines or drugs?	
How did your food cravings and aversions change during pregnancy?	
Were there any particular complications at birth?	
Caesarian or natural birth?	

27	<u>ANY COMMENTS YOU MAY WISH TO ADD:</u>