Lifesong Healing
Child Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be absolutely confidential. If you have any questions, please ask. Write on the back if more space is needed.

Date_____

Name_____ Date of Birth_____ Age____ Gender: ☐Male ☐Female

Address_____ City_____ State_____ Zip_____

Parents: _____

Mother's Phone: (home)_____ (cell)_____ (work)_____E-mail: _____

Father's Phone: (home)_____ (cell)_____ (work)_____E-mail: _____

Height_____ Weight_____ Last Grade Completed_____Difficulties in School _____

Family Physician_____ Last seen (date)_____ Referred by_____

Have you been treated with Homeopathy or other Alternative Healing Techniques in the past? ☐ Yes ☐ No Explain: _____

_____

_____

What are the main problems you need help with? When did they begin?_____

_____

_____

Can you trace the origin of any present condition to any particular circumstance? (accident, illness, grief, mental upset, etc.)_____

_____

_____

In what way do these problems interfere with your daily activities? _____

_____

_____

What diagnosis have you been given for these problems? By whom?_____

_____

What kinds of treatment have you tried?_____

_____

Which of the following have you experienced or are suffering from now:

☐Anemia	☐Appendicitis	☐ Asthma	☐Bedwetting	☐Bladder/Kidney Problems
☐Breathing Problems	☐Burns	☐Cancer	☐Chicken Pox	☐Cold Sores
☐Colic	☐Constipation	☐Depression	☐Diabetes	☐Diarrhea
☐Digestive Problems	☐Ear Infections	☐Emotional Difficulties	☐Eczema	☐Frequent Colds
☐Hard to Please	☐Hay Fever	☐Heart Murmur	☐Hepatitis	☐Herpes
☐Influenza	☐Injuries	☐Jaundice	☐Lack of Energy	☐Learning Disabilities
☐Measles	☐Mononucleosis	☐Much Crying	☐Mumps	☐Nervousness
☐Night Terrors	☐Nosebleeds	☐Parasites/Worms	☐Respiratory Problems	☐Rheumatic Fever
☐Seizures	☐Sexual/Other Abuse	☐Skin Problems	☐Sinusitis	☐Speech Problems
☐Tonsillitis	☐Undescended Testicle	☐Vision Problems	☐Warts	☐Whooping Cough

Other (include chronic illnesses)_____

_____

_____

Surgeries (type and date)_____

_____

Significant physical trauma or hospitalizations (auto accidents, falls, concussions, etc.)_____

_____

_____

Have you used antibiotics in the past?_____Describe_____

Have you received all recommended vaccinations?_____

Adverse reactions? _____

Birth History (prolonged labor, forceps delivery, breech, etc.)_____

_____

Allergies & Sensitivities (drugs, chemicals, foods, etc) & how do you react? _____

_____

_____

Significant emotional trauma_____

_____

_____

Family Medical History: (Please indicate which family member)

☐Cancer_____ ☐High Blood Pressure_____ ☐Thyroid Disease_____

☐Seizures_____ ☐Heart Disease_____ ☐Diabetes_____

☐Hepatitis_____ ☐Anemia_____ ☐Asthma_____

☐Kidney Disease_____ ☐ Other_____

Medicines taken within the last two months (prescription, over the counter, vitamins, herbs, etc.) _____

_____

_____

Do you exercise regularly? ☐Yes ☐No Please describe_____

_____

Have you ever been on a restricted diet? ☐Yes ☐No Please describe_____

_____

Please describe your average daily diet:

Morning_____

Afternoon_____

Evening_____

Snacks_____

Favorite Foods_____

Please check any symptoms you have had in the last three months:

General

__ Pain: Where:_____
Level (1 - 10)_____
__ Energy level (1 - 10)_____
__ Sudden energy drop
Time of day_____
__ Localized weakness
Where_____
__ Fatigue
__ Poor sleep
__ Sleep disorder
__ Fevers
__ Chills
__ Sweat easily
__ Night sweats
__ Bleed or bruise easily
__ Edema
Where?_____
__ Tremors
__ Poor balance
__ Weight Gain
__ Weight Loss

Head, Eyes, Ears, Nose & Throat

__ Dizziness
__ Migraines/ Headaches
When?_____
Where?_____
__ Facial Pain
__ Glasses
__ Poor vision
__ Night blindness
__ Blurry vision
__ Color Blindness
__ Blind field
__ Spots in front of eyes/floaters
__ Eye Pain
__ Eye Strain
__ Eye dryness
__ Excessive tearing
__ Discharge from eyes
__ Poor hearing
__ Ringing in ears
__ Earaches
__ Discharge from ear
__ Hearing aide
__ Nose Bleeds
__ Sinus congestion
__ Nasal drainage
__ Loss of consciousness
__ Grinding teeth
__ Teeth problems
__ Teething problems
__ Jaw clicks
__ Concussions
__ Recurrent sore throats
__ Hoarseness
__ Sore on lips or tongue
__ Other_____
_____
_____

Skin and Hair

__ Rashes
__ Itching
__Excess perspiration
__Foul odor to perspiration
__ Change in hair or skin
__ Ulcerations
__ Eczema
__ Oozing or skin lesion
__ Hives
__ Pimples
__ Recent moles
__ Loss of hair
__ Dandruff
__ Foot fungus
__Other_____
_____
_____

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest discomfort/pain
__ Heart Palpitations
__ Cold hands or feet
__ Swelling of hands
__ Swelling of feet
__ Blood clots
__ Fainting
__Other_____
_____
_____

Respiratory
__ Allergies
__ Cough
__ Asthma/wheezing
__ Pain with a deep breath
__ Shortness of breath
__ Difficulty inhaling
__ Difficulty exhaling
__ Production of phlegm
What color?_____
__ Coughing blood
__ Pneumonia
__ Bronchitis
__ Other_____
_____
_____

Musculo-Skeletal
__ Neck or shoulder pain
__ Back pain
__ Elbow pain
__ Hand/wrist pain
__ Hip pain
__ Knee pain
__ Foot/ankle pain
__ Muscle pain
__ Muscle weakness
__ Other_____
_____
_____

Urinary
__ Pain on urination
__ Urgency or frequent urination
__ Profuse urination
__ Retention of urination
__ Blood in urine
__ Decrease in flow
__ Dribbling
__ Kidney stones
__ Do you wake up to urinate?
Yes___ No___
How often? _____
Color? _____
__Other_____
_____

_____

Diet/Gastrointestinal
__ Peculiar taste or smells
__ Strong thirst (cold or hot)
__ Thirst, no desire to drink
__ Change in appetite
__ Poor appetite
__ Bad Breath
__ Digestive Allergies
__ Nausea
__ Vomiting
__ Heartburn/Indigestion
__ Belching
__ Diarrhea
__ Constipation
__ Chronic laxative use
__ Blood in stools
__ Black stools
__ Abdominal pain or cramps
__ Abdomen tense or firm
__ Abdominal distention
__ Epigastric pain - better__
or worse__ with pressure
__ Gas
__ Rectal pain
__ Hemorrhoids
__Other _____
_____
_____

Psycho-emotional
__ Insomnia
__ Irritability
__ Anger
__ Loss of control/violence potential
__ Depression
__ Easily susceptible to stress
__ Anxiety
__Fears (describe)_____
_____
_____
__ Substance abuse (describe)_____
_____
_____
__ Have you been treated for emotional problems?
__ Have you ever considered or attempted suicide?
__Other_____
_____
_____

Neurological
__ Seizures
__ Areas of numbness
__ Weakness
__ Concussion
__ Loss of consciousness
__ Vertigo or dizziness
__ Lack of coordination
__ Loss of balance
__ Poor memory
__Other_____
_____
_____

Other Concerns_____