Homeopathic Health Clinic

Minneapolis/St. Paul, Minnesota
www.homeopathichealthclinic.com

CHILD HEALTH INVENTORY

Name of Child _____ Date of birth _____ Sex: M F Date _____

Address _____

City _____ State_____ Zip _____

Phone _____ Other Phone _____

Name of Mother _____ Occupation _____

Name of Father _____ Occupation _____

Living with ☐ Mother ☐ Father ☐ Guardian _____

MAJOR HEALTH/BEHAVIORAL CONCERNS (IN ORDER OF IMPORTANCE) **SINCE**

1. _____

2. _____

3. _____

Is there any condition, trauma, or incident after which your child has never been totally well again? ☐ No ☐ Yes; If so, what?

_____

_____

SYMPTOMS (MARK "C" FOR CURRENT SYMPTOMS AND "P" FOR PAST SYMPTOMS)

____ Acne
____ Hives
____ Hair Loss
____ Eczema
____ Chronic Rash
____ Cradle Cap
____ Asthma
____ Pneumonia
____ Wheezing
____ Rubella
____ Measles
____ Tonsilitis/Strep
____ Mumps
____ Rheumatic Fever
____ Scarlet Fever
____ Chicken Pox
____ Ear Infections
____ Thrush
____ Sinus Infections
____ Frequent Urination
____ Burning Urination
____ Bloody Urine
____ Anemia
____ Easy Bruising
____ Bleeding Tendency
____ Nosebleeds
____ Dizzy Spells
____ Hearing Loss
____ Motion/Car Sickness
____ Nervous
____ Frequent Headaches
____ Joint Pains
____ Flat Feet
____ Excessive Fatigue
____ Unusual Fears
____ Cries Easily
____ Heart Murmur
____ Sensitive to Light

IMMUNIZATIONS ☐ NA; child not vaccinated ☐ Unknown _____

____ Measles, Mumps, Rubella (MMR)
____ Varicella
____ Diphtheria, Tetanus, Pertussis (DTaP)
____ Polio
____ Hep A ____ Hep B
____ Others _____

Any reactions to any of the above? ☐ No ☐ Yes; If so, which ones and what type of reaction?

_____

ANY OF THE FOLLOWING PROBLEMS FOR MOTHER DURING THE PREGNANCY?

____ Anemia
____ Spotting, Bleeding
____ Morning Sickness
____ Kidney/Bladder Infections
____ Vaginal Infections

____ High Blood Sugar
____ High Blood Pressure
____ Varicose Veins
____ Thyroid Problems
____ Preeclampsia/Eclampsia

____ Excess Sugar Use
____ Excess Alcohol Use
____ Recreational Drug Use
____ Previous Miscarriages/ Abortions

____ Emotional Trauma
____ Physical Trauma
____ Other _____
_____

PRENATAL & BIRTH HISTORY

Fullterm, premature, late _____ Complications, if any _____

Length of labor _____ Vaginal or Caesarean section _____

Child's birth weight _____ Anesthetics, drugs _____

Mother's age at conception _____ Forceps/Vacuum suction _____

COMPLETE IF CHILD IS LESS THAN 3 YEARS OLD - DEVELOPMENTAL HISTORY :

Any of the following problems during infancy?

____ Birth Defects
____ "Blue Baby"
____ Cerebral Palsy

____ Diarrhea/Constipation
____ Feeding Difficulties
____ Fever

____ Jaundice
____ Rashes
____ Seizures

____ Colic
____ Injuries
Other _____

Was child breastfed? ☐ No ☐ Yes; for how long? _____ Any problems? _____

Was child put on formula? ☐ No ☐ Yes; what kind? _____ Any problems? _____

Age at which solid foods introduced _____ Negative reaction to any foods? _____

Please indicate if there were any problems with the following and approximate age when activity first started **Age**

Holding head up while on stomach _____ _____

Rolling from front to back and back to front _____ _____

Sitting with and without support _____ _____

Crawling _____ _____

Teething _____ _____

Talking (first word, combination of words, sentences) _____ _____

Walking with and without support _____ _____

Toilet training _____ _____

Any particular habits (thumb sucking, nail biting, head banging, rocking) _____ _____

Any nightmares, terrors, or sleepwalking _____ _____

DIGESTION

____ Weak appetite
____ Strong appetite
____ Body/breath odor
____ Excess gas
____ Abdominal pains
____ Vomiting
____ Canker sores
____ Bloating
____ # Bowel movements/day
____ Constipation
____ Diarrhea
Stool Color _____

SLEEP

____ Light
____ Deep
____ Lacking
____ Excess
____ Bedwetting
____ Night sweats
____ Difficulty falling asleep
____ Nightmares

Position _____

IMMUNE SYSTEM

____ Good
____ Poor
____ Frequent colds/flu
____ Chronic coughs
____ Sore throat
____ High fevers

MENTAL/EMOTIONAL

How does your child express the following emotions?

Anger _____

Sadness _____

Anxiety _____

Happiness _____

Fear _____

What fears does your child have _____

List any major experiences of grief/loss in your child's life and how your child has coped with them: _____

_____

DIET

List any foods he/she craves, regardless of their nutritional value _____

List any foods he/she reacts badly to and how he/she reacts _____

_____

Is he/she thirsty? ☐ No ☐ Yes Approximate amount of plain water he/she drinks each day _____

FAMILY HISTORY (INDICATE MATERNAL WITH "M" AND PATERNAL WITH "P")

____ Alcohol
____ Allergies/Hay fever
____ Anemia
____ Arthritis
____ Asthma
____ Bleeding
____ Birth Defects
____ Cancer
____ Diabetes
____ Eczema
____ Epilepsy/Seizures
____ Glaucoma
____ Heart Disease
____ High Blood Pressure
____ Kidney Disease
____ Mental Illness
____ Stroke
____ Thyroid (hyper/hypo)
____ Tuberculosis
____ Other _____