HOMEOPATHIC CHILD QUESTIONNAIRE

Kimberly Woods Homeopathic Consultant Email: Homehealthrevolution@live.com
845 532 0624 CELL / TEXT www.NaturalHealthSource.us

INSTRUCTIONS: Please be brief and to the point, 10 pages or less. The language and specific symptoms of your body are important pieces of the puzzle. If you don't know, no worries, we'll figure it out together. If there is anything you are controlling with herbs, supplements, therapy, meditation, etc. List that as a chief complaint. Your natural tendencies and patterns are valuable clues. The timeline is important, please state age on the left, not the year and leave a space between each entry. Please email this form at least 4 hours before the appointment.

Child's Name: _____ Today's Date: _____

Parent(s) Name(s): _____Address:

_____

Email:_____

Phone: (day) _____(eve)_____ _____Child's Date

of Birth: _____Age:____ ____Height: _____Weight: _____Referred by:

_____Type of payment? Paypal or Venmo_____

To be answered by the child's mother, if possible. Please keep answers brief and to the point. The whole document when finished 10 pages or less.

1. What is the child's chief complaint (CC)?
2. When did this problem begin? What happened in the child's life around that time? What do you think caused it?
3. What aggravates the CC (certain types of food or weather, movement, light noise, heat/cold being at the seashore, or anything else that you can think of?
4. At what time of day or night is the CC the worst? Specify an hour if you can.
5. What symptoms can you identify that accompany the CC?
6. What was your predominant emotional state when pregnant with this child?
7. During the pregnancy did you suffer any particular shocks or traumas or losses?
8. Did you take any drugs?
9. How did your food cravings and aversions change during your pregnancy?
10. Were there any particular complications at birth?
11. At what age did the child reach these stages?

    a. Weaning
    b. Closing of fontanels
    c. First milk teeth
    d. Talking

e. Toilet training
f. First permanent teeth
g. Crawling
h. Walking

12. How did the child react to the following situations? Please try to think of mental and emotional reactions, as well as any physical symptoms that may have developed.
    a. Vaccinations
    b. Birth of younger sibling
    c. Starting daycare regularly
    d. First day at school
    e. Spending the night with a friend
    f. Traveling with the family
    g. Going away without the family
13. How many rounds of antibiotics has the child had, and for what?
14. Any skin conditions treated with cortisone cream?
15. Did the child suffer from a childhood disease with very severe symptoms? (measles, chicken pox, German measles, croup, mumps, etc.)
16. When ill or upset, does the child tend to cling to you or want to be left alone?
17. What is the child's behavior in playing with other children? Does it make a difference if the other children are older or younger?
18. What feedback do you get from you child's teachers about behavior in class?
19. What pets do you have and what is your child's attitude toward them?
20. What types of food does your child crave? Please be as specific as possible and list as many as you can.
21. What types of food does your child refuse to eat?
22. What types of food does your child react badly to? Whether physically (bloating, Diarrhea, etc.) or behaviorally, and what are the reactions?
23. Any fears that are unusual for a child of your child's age? (of the dark, being alone, lightening, thunder, etc.) Are there nightmares?
24. Is the child chilly? Is there excessive perspiration on the head and/or feet?
25. Is the child affectionate when not sick?
26. Is the child unusually sympathetic (showing concerns for the suffering of other children, animals, etc.)?
27. Does the child like music? What kind? Like dancing? Do symptoms (like restlessness) improve with music?

28. Is the child obstinate? How is this expressed?
29. Is the child fastidious?
30. Is the child sensitive to criticism or reprimand?
31. Can you think of any unusual or distinctive things about you child, behavior, fears or fantasies, desires attachments, preferences, in clothing, etc.?

32. **Please give a timeline for the child** with all possible traumas, in general vaccine history, diseases, important events, deaths in the family. Describe the reaction of your child towards these events. Type the age for each entry, not the year.

33. Is there cancer, diabetes, alcoholism, mental illness, early heart issues, Lyme disease, arthritis or tuberculosis, etc. in your family history?