

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)

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

IMMUNIZATIONS NA; child not vaccinated Unknown _____

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Excess Sugar Use | <input type="checkbox"/> Emotional Trauma |
| <input type="checkbox"/> Spotting, Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Excess Alcohol Use | <input type="checkbox"/> Physical Trauma |
| <input type="checkbox"/> Morning Sickness | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Kidney/Bladder Infections | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Previous Miscarriages/ Abortions | _____ |
| <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Preeclampsia/Eclampsia | | _____ |

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?

- | | | | |
|---|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Colic |
| <input type="checkbox"/> "Blue Baby" | <input type="checkbox"/> Feeding Difficulties | <input type="checkbox"/> Rashes | <input type="checkbox"/> Injuries |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fever | <input type="checkbox"/> Seizures | 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

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Weak appetite | <input type="checkbox"/> Excess gas | <input type="checkbox"/> Canker sores | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Abdominal pains | <input type="checkbox"/> Bloating | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Body/breath odor | <input type="checkbox"/> Vomiting | <input type="checkbox"/> # Bowel movements/day | Stool Color _____ |

SLEEP

- | | | | |
|--------------------------------|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Light | <input type="checkbox"/> Lacking | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Excess | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Nightmares |

Position _____

IMMUNE SYSTEM

- | | | | |
|-------------------------------|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Good | <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Sore throat | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Poor | <input type="checkbox"/> Chronic coughs | | |

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")

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid (hyper/hypo) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |