Healing Heart Homeopathy

CHILD HEALTH INVENTORY

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

Address _____

City _____ State._____ Zip _____

Email Address _____

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 (Circle all CURRENT and 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) ____ 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?

Anemia	High Blood Sugar	Excess Sugar Use	Emotional Trauma
Spotting, Bleeding	High Blood Pressure	Excess Alcohol Use	Physical Trauma
Morning Sickness	Varicose Veins	Recreational Drug Use	Other _____
Kidney/Bladder Infections	Thyroid Problems	Previous Miscarriages/	_____
Vaginal Infections	_ Preeclampsia / Eclampsia	Abortions	

PRENATAL & BIRTH HISTORY

Full-term, 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 4 YEARS OLD·
DEVELOPMENTAL HISTORY:

Any of the following problems during infancy?

Birth Defects	Diarrhea/Constipation	Jaundice	Colic
"Blue Baby"	Feeding Difficulties	Rashes	Injuries
Cerebral Palsy	Fever	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

_____Weak appetite	_____Excess gas	____Canker sores	Stool Color____
____ Strong appetite	____Abdominal pains	____Bloating	Constipation_____
____ Body/breath odor	____Vomiting	____ _____# BM's per day	Diarrhea_____

SLEEP

___Light	___Lacking	____ Bedwetting	____ Difficulty falling asleep
___Deep	___Excess	_____Night sweats	____ Nightmares

Position _____

IMMUNE SYSTEM (Circle)

Good	Frequent colds / flu	Sore throat	High fevers
Poor	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 all 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: Circle all that apply

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

Prescription Medications and Dosage:

_____
_____
_____
_____
_____

Vitamin and Mineral Supplements Types and Dosage:

_____
_____
_____
_____
_____

List any Complementary Therapy. Previously or Currently Used:

_____
_____
_____
_____
_____

List Anything Else You Feel Would Be Helpful:

_____
_____
_____
_____
_____