Paediatric (childs) Patient Consultation Profile

Please complete the following questionnaire as thoroughly as possible to help Sally understand who you are on a physical, emotional, mental and spiritual level. This will become a part of your confidential records and will not be released unless you have authorized her to do so.

Personal Details:

Full Name: _____ First Name _____ Other Initials: _____

Date of Birth: _____ Age: _____ Gender (sex): _____

Postal Address: _____

_____ Email: _____

Home Phone: _____ Work Phone: _____

Name of parent(s) / carer(s): _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Present Health Concerns (in order of importance): Duration:

1_____ _____

2 _____ _____

3_____ _____

Please describe what you think is the cause of your health conditions (use the back of the page if needed):

_____

_____

_____

_____

_____

Vitamins/Herbs/Supplements that you are taking:

Name / Type	Reason for taking	Dose/day (mg/etc)	For how long	Who prescribed

Drugs (prescription and over-the-counter, that you are now taking):

Name of drug	Reason for drug	Dose (mg/etc)	For how long	Prescribing doctor

Allergies drugs, food, metal, environmental (grass/pollen, etc.):

(Please circle any which are life-threatening)

_____

Are you sensitive to chemical smells? _____

List any chemicals, fumes, and dusts etc. that you are or have been repeatedly exposed to:

_____

Medical/Health History:

Primary Care Doctor/Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Other Current Health Provider(s): _____

Last full physical exam: _____ Results: _____

Date of last urine test: _____ Results: _____

Date of last blood work: _____ Results: _____

Family History

Using the following key, designate which family members have had the following.
List type where parents are present) M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Allergies		Diabetes		Kidney Disease	
Alcoholism		Cancer (type?)		Mental Disorder	
Anemia		Cancer (type?)		Obesity	
Arthritis (Rheumatoid)		Epilepsy		Stroke	
Arthritis (Osteo)		Heart Disease		Thyroid (low/ high)	
Autoimmune Disease		High Blood Pressure		Other	
Bleeding Tendency		High Cholesterol		Other	

Exercise:

Type(s)	How long per session	Frequency	Practiced for how long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sleep Habits:

How many hours/night: _____ Do you wake refreshed? _____ If not why? _____

Do you have problems (circle as appropriate): falling asleep staying asleep waking up in the morning

Energy level (average per week, circle one): (lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress level (average per week, circle one): (lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

How do you cope with stress? _____

Who do you talk to about your problems? _____

What do for fun and how often? _____

Diet history (include any liquid tea, coffee, etc., in description):

What was breakfast yesterday? _____

What was lunch yesterday? _____

What was dinner yesterday? _____

List snacks you had yesterday: _____

How many glasses of **plain water** do you drink per day? _____filtered, tap, distilled, well water

Do you practice any special diet restrictions?_____

Eliminations (please complete):

Bowel Movement Habits:
Frequency: (how often) _____ Consistency: (hard, formed, soft, watery)_____

Color: (black, brown, yellow, green, white) _____

Any mucus or blood on stool?(which) _____ Does stool pass easily? _____

Urine Habits:
Frequency: (how often per 24hour period) ___ Character: (clear, cloudy, concentrated, dilute) _____

Color: (dark yellow, light yellow, green, colorless) _____

Any blood or sediment? (which) _____

Any pain, incontinence, other urinary symptoms? _____

Digestion:
Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food?
(circle or specify): _____

_____

Review of Symptoms

Indicate if you **now** have, or circle if you **previously have had** any of the following.
List type where appropriate)

Anemia
Blood diseases
Fatigue (affecting daily living)
Dizziness (more than 5 seconds)
Recurrent headaches
Loss of hearing
Ringing in ears
Recent loss or change in vision

Eye pain
Frequent sore throat
Persistent numbness or weakness
Nervousness/depression
Skin problems (type)
Brittle nails
Recent hair loss
Allergies
Frequent sinus infections
Cancer (type)
Asthma
Difficulty breathing
Chronic bronchitis
Tuberculosis
Stomach ulcers
Constipation
Diarrhea
Lasting nausea
Recurrent vomiting
Chest pain
Heart disease
Heart failure
Irregular heart beat
Hemorrhoids
Unusually severe bruising
Frequent nose bleeds
Varicose veins
Poor circulation
Stroke
Kidney failure
Kidney stones
Kidney infection
Sexually transmitted diseases
Thyroid problems
Diabetes
Significant swelling of ankles
Liver disease
Hepatitis
Arthritis
Persistent neck pain /
Stiffness
Persistent low
Back pain / stiffness
Bursitis
Hot and swollen joints
Prostate enlargement
Female cramps
Excessive menstrual flow
Hot flushes
Irregular menstrual cycles
Fibrocystic breasts

List other symptoms:

Send the form to:

Sally Horrobin ND
The Natural Root Wellness Clinic, 11 Periton Lane
Minehead, Somerset, TA24 8AQ