



**Kids' Ear Clinic**  
Manuka Health Centre  
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Please fill out as much of this form as you can and email it back to us at the Kids' Ear Clinic prior to your appointment. If available, please bring results of relevant tests.

Your answers will help us to prescribe an appropriate homeopathic medicine for you and allow us to make the most of our consultation time together.

### **Adult Questionnaire**

Date:
Name:
Address:
Post code:
Phone:
Mobile:
Email:

Date of Birth:

Ethnicity:

Occupation:

Family Doctor:

How did you find out about the Kids' Ear Clinic?

What would you like to be treated for?

Have you had a diagnosis from a doctor for the above condition(s)? If so what was it?

When did this problem/these problems first occur?

What symptoms signalled the onset of the problem(s)?

How often does the problem(s) tend to occur and how long does it usually last?

Can you trace the origin of any of your symptoms to any particular circumstance? (e.g. accident, grief, mental upset, life change etc)

Is there anything at all that you've noticed makes your symptoms better or worse?

Are you better/worse (e.g. energy, moods, symptoms, appetite) at a particular time of day?

What other treatments have you tried? How successful have they been? Please include any previous homeopathic remedies if known.

Have you ever had any health problems after which you have never been totally well? If yes please describe:

Please list any major operations/surgery?

What medications, supplements or treatments are you currently having?

Please \* any of the following conditions that you have had:

Allergies	Colic	Influenza	Rubella
Asthma	Eczema	Measles	Streptococcal sore throat
Bedwetting	Frequent colds	Meningitis	Tonsillitis
Chickenpox	Glandular Fever	Mumps	Warts
Cold sores	Hay fever	Pneumonia	Worms

Please mention any other current health issues you have:

Are there any smokers in your household?

Please \* any of the following conditions that run in your family background (blood relatives):

Alcoholism, substance abuse	Depression	Heart Disease
Allergies	Diabetes	Pneumonia
Arthritis	Eczema	Psoriasis
Asthma	Glandular Fever	Throat, nose, or ear problems
Cancer	Hay fever	Tuberculosis

Vaccination:

Have you been (please circle appropriate option):

(1) fully vaccinated (please also list any vaccinations given overseas)

(2) partially vaccinated (please list vaccinations given)

(3) not vaccinated

What reaction to the vaccinations did you have?

Have you any food intolerances?

How is your appetite?

Do you have any strong food preferences? If so, please list:

Any food dislikes or foods that cause upset? If yes please describe:

What do you typically eat for:

Breakfast

Lunch

Dinner

Snacks

Digestion: any problems? bowels, urine, constipation, wind, burping, abdominal pain? If yes, please describe:

Drinks: what do you like to drink? How much per day?

Sleep: Any problems with sleep? (e.g. difficulty getting to sleep or staying asleep, frequent waking, sleep walking, talking in your sleep, drooling, grinding of teeth, etc) If yes, please describe:

Any recurring or significant dreams?

Do you snore?

Temperament: briefly describe your usual temperament:

Temperament when sick?

How do you cope with change in your life?

Body Temperature: Do you generally feel the heat or the cold more than average. If so, please specify which:

Do you have cold/hot hands and/or feet?

Perspiration: How sweaty are you? Where is the sweat? When do you sweat most?

Do you suffer from any phobias, fears, or recurrent anxieties? If yes, please describe:

Weather: How are you affected by different kinds of weather? (eg thunderstorm, damp, hot weather)

Is there anything else you think we should know about, in order to better help us to help you?

Thank you from the Kids' Ear Clinic Team for taking the time to fill out this questionnaire.