



Kids' Ear Clinic
Manuka Health Centre
11 Hector Street, Petone
E: kidsearclinic@xtra.co.nz
www.kidsearclinic.co.nz
P: 04 569 6165

Parents, 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, and Plunket book.

Your answers will help us in prescribing a good homeopathic medicine for your child and allow us to make the most of our consultation time together.

QUESTIONNAIRE FOR KIDS WITH EAR PROBLEMS

Date:	
Patient's Name:	
Parents' Names:	
Address: <i>(please include post code if known)</i>	
Phone: Home Mobile(s)	
Email:	
Patient's D.O.B: Age of siblings	Age:
Ethnicity:	
Family Doctor:	
How did you find out about the Kids' Ear Clinic?	
What would you like your child to be treated for?	

When did this problem/these problems first occur?
How many visits to the doctor do you think you have made for the problem(s)?
What symptoms signaled 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 child's 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 child's symptoms noticeably better or worse?
Is your child better/worse (e.g. mood, energy, ear symptoms, appetite) at a particular time of the day?
Do the ear problems typically occur in both ears? If it is one ear, is it usually the same ear? If so, which ear?
Is there a discharge from the ears? If yes, please describe the colour, consistency and smell of the discharge:
Are there any other symptoms that accompany your child's ear symptoms?
What other treatments have you tried? How successful have they been? Please include any homeopathic treatment, including remedies if known.
Has your child ever had any health problems after which they have never been totally well?
Please list any major operations/surgery?

What medications, supplements or treatments is your child currently having?

Please * any of the following conditions that your child has had:

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

Please mention any other current health issues your child has that are of concern:

Are there any smokers in the household?

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

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

Other:

Mother's health during pregnancy: List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications etc

Birth History: Full term: ____ Premature: ____ Late: ____
(Please specify number of weeks)

Weight of child at birth? Length of labour?

Complications?

Apgars at birth out of 10 (if known):

Any food dislikes or foods that cause upset?
Digestion: any problems? bowels, urine, constipation, wind, burping, tummy pain?
Drinks: what does your child like to drink? How much per day?
Teething: any teething problems?
Sleep: How does your child sleep?
Does your child have nightmares?
Does your child snore?
Does your child grind teeth during sleep?
What position does your child sleep in?
Temperament: briefly describe your child's usual temperament:
Temperament when sick:
How does your child cope with change in his/her life?
Body Temperature: Does your child generally feel the heat or the cold more than average. If so, please specify which:
Does your child have cold/hot hands and/or feet?

Perspiration: How sweaty is your child? Where is the sweat?

Behaviour: are there any situations that are hard to manage or repeated behaviour that concerns you or affect the family? Please specify:

Fears: is your child frightened of anything?

Weather: is your child affected in any way by different kinds of weather (eg thunderstorm, damp, wind, hot weather)?

Is there anything else you would like to mention?

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