



Kids' Ear Clinic
Manuka Health Centre
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GENERAL KIDS' QUESTIONNAIRE

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.

Date:	
Patient's Name:	
Parents' Names:	
Address:	
Postcode:	
Phone: Home Mobile(s)	
Email:	
Patient's D.O.B: Age of siblings:	Age:
Family Doctor:	
Ethnicity:	

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?
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?
How many visits to the doctor do you think you have made for the problem(s)?
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, symptoms, appetite) at a particular time of day?
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	
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):			

Vaccination:

Has your child been (please circle or indicate the appropriate option):

(1) fully vaccinated (please also list any vaccinations given overseas and tell us whether your child has had the Menzb vaccination).

(2) partially vaccinated (please list vaccinations given)

(3) not vaccinated

What reaction to the vaccinations did your child have?

Milestones: Approximate age your child began:

Sitting:

Crawling:

Walking:

Talking:

Feeding: Breast-fed?

How long?

Formula?

How long?

Milk/ Soy or other?

Age your child began solids?

Any food intolerances?

What does your child eat on a normal day:

Breakfast:

Lunch:

Dinner:

Snacks:

How is your child's appetite?

Does your child have any strong food preferences?

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 hard to manage or repeated behaviour which concern you/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, rain, 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.