HOMEOWORKS PLLC
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Homeopathic Child/ Adolescent Case-Taking Questionnaire

Name: Last: _____ First: _____ Middle: _____

Address: _____

Telephone: (home) : _____ **(mobile):** _____

Date of Birth: _____ (Month/Date/Year)

Gender (circle one): Male Female Transgender

Weight: ____ **Height**: ____

Does your child have any food or drug allergies? Yes No

If yes, allergies to what? (include foods and medicines)

If you are the patient's parent or guardian, what is your name? _____

Note: While you are completing the questionnaire, please keep in mind the symptom's frequency and strength. For example, when your child has a fever, is there extreme irritability and capriciousness? Does the fever only come intermittently or is it all the time? Or is you child weepy and needy?

PAST MEDICAL HISTORY

In the list below, check ALL major illnesses your child has had and give any relevant details on the other side of this page:

Meningitis __	Whooping cough __	Ear Infections __
Food Poisoning __	Malaria __	Frequent Colds __
Worms __	Jaundice __	Sore Throats __
Diarrhea __	Liver disease ___	Sinusitis__
Measles __	Spleen disease __	Bronchitis__
German measles __	Malnutrition __	Pneumonia __
Chickenpox __	Rickets __	Asthma __
Smallpox __	Rheumatism __	Pleurisy__
Mumps __	Backache __	Tuberculosis __

Diabetes or diabetic complications?

Any of the following surgeries?

Ears __	Appendix __	Hydrocele __
Tonsils __	Hernia __	Undescended testes __
Adenoids __	Hemorrhoids __	Other:
Abdomen __	Phimosis __	

Have your child had anesthesia: general or local? If yes, what was it for?

Any lumbar punctures? If yes, for what reason?

As far as you know, are there any headaches, numbness, cramps, spasms, twitching, convulsions, numbness, tingling, or paralysis?

Any major accidents or injury to body or head? Was there a loss of consciousness? Explain.

Any major bleeding from any part of the body?

If there has been a history of recurrent colds or infection, was it treated with antibiotics?

Has your child had any of the following skin conditions?

Pimples__	Carbuncles __	Eczema __
Warts __	Ringworm __	Tumors __
Boils __	Scabies __	Styes __

Where were they? When were these treated? How were they treated?

Any other comments?

FAMILY MEDICAL HISTORY

To the best of your knowledge, which diseases exist in your family?

Anemia __	Tuberculosis __	Stroke/Paralysis __
Cancer __	COPD/Emphysema __	Hypertension __
Diabetes __	Leprosy __	Heart trouble __
Depression __	Seizure disorder __	Kidney disease __
Bipolar disorder__	Bleeding disorders __	Liver disease__
Schizophrenia __	Hives __	Other: __
Anxiety __	Eczema __	
Rheumatism __	Asthma __	

Please include whether the family members are alive or deceased, current medical conditions, and/or cause of death. If not known, please mark unknown.

Paternal Grandfather: Paternal Grandmother:

Maternal Grandfather: Maternal Grandmother:

Father: Mother:

Paternal Uncles: Paternal Aunts:

Maternal Uncles: Maternal Aunts:

How many brothers or sisters are there?

What are their ages and current medical conditions? Include any siblings that have died.

PERSONAL MEDICAL HISTORY

Prenatal History:

1. What information do you know about your child's prenatal history?

2. What was your mood during pregnancy?

3. Were there any difficulties or complications surrounding your child's birth?

4. Did you experience any trauma or shock during pregnancy?

5. Did you have any problems during pregnancy?

6. Did you take legal or illegal drugs during her pregnancy? If so, what were they?

7. How old was your child when he/she reached these stages of development?

Teething _____	Standing _____
Urine Control _____	Walking _____
Bed-wetting _____	Speaking ____
Sitting _____	Closing of fontanels _____
Crawling ____	

8. Does/did your child eat chalk, paint, lime, dirt, ice, etc.?

9. In school, did you have any learning disabilities?

10. Mark if any animal/insect bites such as:

Dog __	Scorpion __
Cat __	Spider __
Rat __	Other __
Snake __	

11. Has your child had any anti-rabies, anti-venom, or other treatments? If so, which ones?

12. Vaccinations and Inoculations: Indicate which vaccines you received and the number of times you were vaccinated for the following:

Smallpox	Varicella	Hepatitis B
Polio	B.C.G.	HPV
Cholera	Typhoid	Influenza
MMR	Pneumococcal	Other:
DTP	Tetanus	
Meningococcal	Hepatitis A	

13. Did your child have any particular or severe reaction after having any of above vaccinations of inoculations? If so, please be specific and detailed.

14. Has your child ever been hospitalized? If so, when and for what?

15. If applicable, list the types of dental fillings and what types of fillings your child has: amalgam, ceramic, gold, mercury. Does your child get frequent cavities?

16. Is your child taking any medications, supplements, vitamins? What are they and what is the dosage?

GENERAL SYMPTOMS

1. What is your child's main complaint?

2. What are the symptoms of your child's complaint?

3. When did this complaint first occur?

4. Can you trace the origin of this complaint to any incident or mental upset?

5. Is there a specific time of day or night when the symptoms are better or worse? What hour?

6. Are there any particular or unusual sensations that accompany the complaint?

7. Does the complaint have a precise location?

8. Are there any symptoms that make this complaint feel better or worse? For example, are the symptoms affected by weather, temperature (heat or cold), movement, certain foods, light or noise?

GENERAL QUESTIONS

1. Has your child experienced any mental, emotional, or physical traumas? How did your child respond to these events?

2. Is your child affected by sudden changes in temperature? (for example, hot to cold, walking into a hot room/cold room)

3. Does your child have any reaction to cold, hot, dry, wet or windy weather?

4. Does your child appear to feel better or worse in the open air?

5. Does your child have any strong reactions to sudden changes in weather?

6. Does your child seem to have any reactions to drafts?

7. Is your child very sensitive to bright light or loud noises?

8. Is your child sensitive to being touched?

9. Before, during or after a storm, does your child have any strong reactions?

10. Does your child never sit still?

11. Does your child love dancing to loud music?

12. Does your child have any very strong food dislikes or cravings? Are there foods your child refuses to eat?

13. Does your child experience bloating or distention before, during or after eating?

14. Does the bloating cause cramping, gas, or diarrhea?

15. Does your child suffer from diarrhea or constipation?

16. Does your child drink an adequate amount of fluid during the day? How much? What fluids does your child prefer to drink?

17. Does your child perspire? If so, where? Is there an odor to the perspiration?

18. Does your child have any difficulties sleeping?

19. Does your child sleep in any particular position?

20. Does your child have any nightmares or night terrors?

21. Does your child snore, moan, talk, cry, grind teeth, or toss and turn during sleep?

22. When ill or upset, does your child cling to you or prefer being left alone?

23. Is your child sensitive to criticism or reprimand?

24. Is your child meticulous or a perfectionist?

25. Does your child fear cats or dogs? The dark? Being alone? Any other fears?

26. Do you notice your child being jealous of their siblings or other children?

27. Can your child be obstinate?