

Date: _____



**THE KLEIN
CENTER FOR
Holistic Medicine**

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Balanced therapies for ultimate health

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Pediatric Health Questionair

Patient Name: _____

Parent/Guardian Name: _____

Relation to Patient: _____

What are your main concerns? (list in order of importance, from most important to least) Also, please describe how the condition developed and any factors that may have played a role in its onset and continuance.

Significant Medical History (please include birth and developmental problems)

Hospitalizations & Surgeries

Year Reason

Prescription Medications

Name Dose

Natural Supplements, Vitamins, Etc

Known Allergies (medications & food)

Family History

Age Health

Father: _____

Mother: _____

Siblings: _____

Are there any serious medical conditions that run in the family?

Review of Body Systems (Please circle "Y" for current conditions and "P" for past conditions, otherwise leave blank those that do not apply.)

General

Abnormal weight gain/loss Y P
Fatigue Y P
Fevers Y P

Head

Headaches Y P
Dizziness/fainting Y P
Visual Problems Y P
Strabismus (lazy eye) Y P
Frequent Conjunctivitis (pink eye) Y P

Ears

Frequent ear infections Y P
Hearing problems Y P

Nose & throat

Frequent colds Y P
Chronic congestion Y P
Recurrent strep throat Y P
Recurrent cough Y P
Dental problems Y P

Chest

Recurrent bronchitis Y P

Abdomen

Frequent stomach aches Y P
Diarrhea not related to acute illness Y P
Constipation Y P
Excessive gas Y P
Food allergies (known) Y P
Indigestion Y P
Number of bowel movements per day: _____
Are they regular? Y N

Bowel movements are (circle all that apply)

Large Hard
Medium Soft and well formed
Small Thin/long/narrow
Difficult to pass
Variably soft & hard
Loose but not watery
Diarrhea

Appetite

Good Poor Variable

Neck

Frequent/chronic swollen glands Y P

Musculoskeletal

Persistent pain Y P

Asthma	Y	P
Pneumonia	Y	P
Palpitations	Y	P
Heart problems	Y	P
if yes, what?	_____	

Significant injuries/fractures	Y	P
if so, where?	_____	
Deformities	Y	P
if so what?	_____	

Genital-Urinary

Difficulty urinating	Y	P
Bed wetting	Y	P
Premature sexual development	Y	P

Neurological/Psychiatric

Behavior/school problems	Y	P
Attention deficit disorder	Y	P
Tics/nervous habits	Y	P
Poor sleep	Y	P
if so, in what way?	_____	
Nightmares/night terrors	Y	P
Seizures	Y	P
Paralysis, weakness	Y	P

Diet (please describe a normal)

Breakfast: _____

Lunch: _____

Dinner: _____

Please estimate the percentages in your diet of the following foods (total =100%)

_____ Fruit	_____ Grains	_____ Dairy	_____ Vegetables
_____ Meats	_____ Nuts, Beans, Seeds	_____ Packed Microwaved Foods	
_____ "Junk" Foods			

Please estimate the percentages of these protein categories in your diet

_____ Meat	_____ Poultry	_____ Fish	_____ Soy Products
_____ Eggs/Dairy	_____ Other		

How often are sodas consumed?

_____ More than once a week
 _____ Daily
 _____ Several times a week
 _____ Once a week or less

How often is fast food consumed?
