Martha DeMarco
HOMEOPATHY
enhancing health naturally

Questionnaire for Children

Please use extra sheets of paper if necessary

Child's Name:_____ Parents: _____
Address:_____
Primary Parent Contact e-mail:_____
Phone: (home)_____(cell) _____
Parent's marital status:_____ Stepparents? _____
Date of Birth: _____Age:_____Birthweight:_____
Height/Length:_____Weight:_____%tile (if known)_____
Referred by:_____
1. What is the child's chief complaint (CC)?

_____

2. When did this problem begin? What happened in the child's life around that time? What do you think caused it?_____

_____

_____

3. What aggravates the CC (certain types of foods or weather, movement, light, noise, heat/cold, being at the seashore, or anything else that you can think of)?

_____

_____

_____

4. At what time of the day or night is the CC the worst? Specify an hour if you can.

_____

5. What symptoms can you identify that accompany the CC?

_____

_____

6. What was your predominant emotional state when pregnant with this child?

_____

_____

7. During the pregnancy, did you suffer any particular shocks or traumas or losses?

_____

_____

8. Did you take any medication?

_____

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9. How did your food cravings and aversions change during pregnancy?

_____

_____

10. Were there any particular complications at birth?

_____

11. At what age did the child reach these stages:
weaning_____talking_____toilet training_____
crawling_____walking_____

12. How did the child react to these situations? Please try to think of mental and emotional reactions as well as any physical symptoms that may have developed.
Vaccinations_____birth of younger sibling_____starting daycare regularly_____first day at school_____spending the night with a friend_____traveling with the family_____going away to camp etc. without the family_____

13. How many rounds of antibiotics has the child had, and for what?

_____

_____

14. Any skin conditions treated with cortisone cream?

_____

15. Did the child suffer from a childhood disease with very severe symptoms? (measles, chickenpox, German measles, croup, mumps, etc.)?

_____

_____

16. When ill or upset, does the child tend to cling to you or want to be left alone?

_____

_____

17. What is the child's behavior in playing with other children? Does it make a difference if the other kids are older or younger?

_____

_____

18. What feedback do you get from your child's teachers about behavior in class?

_____

_____

19. What pets do you have, and what is your child's attitude towards them?

_____

_____

20. a) What types of food does your child crave? Please be specific.

_____

b) What types of food does she/he refuse to eat? _____
c) What types of food does your child react badly to, whether physically (bloating, diarrhea, etc.) or behaviorally, and what are the reactions?

_____

_____

21. Any fears that are unusual for a child of your child's age (of the dark, being alone, lightning, thunder, etc.) Are there nightmares?

22. Is the child chilly? Is there excessive perspiration on the head and/or feet?

23. Is the child very affectionate when not sick?

24. Is the child unusually sympathetic (showing concern for the suffering of other children, animals, etc.)?

25. Does the child like music? What kind? Like dancing? Do symptoms (like restlessness) improve with music?

26. Is the child obstinate? How is this expressed?

27. Is the child fastidious?

28. Is the child sensitive to criticism and reprimand?

29. Can you think of any unusual or distinctive things about your child—behavior, fears, fantasies, desires, attachments, preferences in clothing, etc.?

30. Give a timeline for the child with all possible traumas, diseases, important events, deaths in the family. Describe the reaction of your child towards these events.

31. Please list any medications, herbs, supplements, or homeopathic remedies your child is currently taking:

32. Credit card information:
Card number: _____ Expiration: _____
Code: _____ Zip code of cc billing address: _____

Please return to martha@demarcohomeopathy.com

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