HEALTH HEALING life CLINIC

Address: 18 Jeffcott St Wavell Heights
Phone: 07 3260 5946
Email: contact@healthhealinglife.com

Child's Name: Age: DOB: Today's Date:

Address: Email:

Home Phone: Mobile: Parent name/s:

How did you hear about us:

Names of any current practitioners:

Emergency contact details

Name: Phone: Relationship to you:

Doctor/GP contact details:

Current Medications:

Main reason for visit:

Health History

Childhood Health (please include major illness, medication and surgery):

Family Medical Health History:

Please list any Current medications/Supplements:

Medication	Reason for taking	Amount/strength	Dosage

Vaccinations:

Up to date ☐
Some but not all ☐
Unvaccinated ☐

Did you vaccinate as per schedule or alternate schedule:

Any reactions to vaccinations or changes in health after a vaccination (if yes, please provide details):

Daily Rhythms

When do you have the most energy? When are you most tired?

Usual sleep time: Usual wake time:

What is your quality of sleep?

Do you experience any of the following:

Nightmares/Night terrors ☐
Calling out/talking in sleep ☐
Grinding teeth in sleep ☐
Bed wetting ☐

Have you any concerns (past or current) around growth, weight or development?: If yes please describe.

Lifestyle Health

Do you suffer from any emotional conditions?

Please describe how this affects you?

Is there anything at kindy/school that stresses, drains, hurts or frustrates you?

Is there anything at home or socially that stresses, drains, hurts or frustrates you?

Food and Digestion

Do you have any known or suspected food allergies or sensitivities?

Please share your normal daily food intake - some people like to keep an actual food diary for a couple of days, you can also bring this along.

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Do you experience any of the following:

Indigestion	☐	Bloating	☐
Reflux	☐	Flatulence	☐
Nausea	☐	Diarrhoea	☐
Burping	☐	Constipation	☐
Stomach pain	☐	Lower Abdominal pain	☐
Vomiting	☐	Bleeding from the bowel	☐

Do you experience food cravings? Please describe particular foods or tastes eg. sweet, salty, fatty, carbohydrate, other.

Are there any foods you dislike or cannot eat?

Do you experience any food related emotional conditions?

Do you experience any of the following before, during or after eating:

	Before	During	After
Lightheaded, faint or dizzy	☐	☐	☐
trembling or shaking hands	☐	☐	☐
Irritability	☐	☐	☐

Nutritional overview

Please tick any of the following symptoms or conditions that you currently experience

EARS	Itchy Ears,	☐
	Hearing loss or Blocked ears	☐
	Ringing or buzzing in ears	☐
	Earache or Ear Infections	☐
EYES	Watery or itchy eyes	☐
	Swollen, reddened or sticky eyelids	☐
	Bags or dark circles under eyes	☐
	Blurred/tunnel vision or visual disturbance	☐
NOSE	Stuffy nose or Nasal discharge	☐
	Sinus congestion or Sinus infection	☐
	Hay fever or Sneezing attacks	☐
	Postnasal drip or Excessive mucus	☐
MOUTH/	Chronic coughing or clearing of throat	☐
THROAT	Frequent gagging or difficulty swallowing	☐
	Sore throat, hoarseness, loss of voice	☐
	Swollen or discoloured tongue, gums, lips	☐
	Mouth ulcers or Sore gums	☐
	Bleeding gums, sensitive teeth	☐
	Cracks in the corner of your mouth	☐
DIGESTIVE	Episodic nausea or vomiting	☐
TRACT	Diarrhoea - Episodic or recurrent	☐
	Constipation – episodic or recurrent	☐
	Abdominal Bloating – episodic or recurrent	☐
	Flatulence – burping, or passing gas	☐
	Heartburn – episodic or recurrent	☐
APPETITE	Loss of appetite	☐
EATING	Food Cravings	☐
BEHAVIOUR	Binge eating / drinking or Compulsive eating	☐
	Excessive weight or weight gain	☐
	Eating when sad or down	☐
	Overeating or eating when not hungry	☐
	Feeling guilty about food	☐
EMOTIONS /	Mood swings	☐
FEELINGS	Anxiety, fear or nervousness	☐
	Anger, irritability, or aggressiveness	☐
	Given up, at a loss	☐
	Teary, sad	☐
	Depleted, low, depressed	☐
	High, excitable, on a rush	☐
MIND /	Poor memory	☐
COGNITION	Confusion, poor comprehension	☐
	Poor concentration	☐
	Poor physical coordination	☐
	Difficulty in making decisions	☐
	Stuttering or Stammering or Slurred speech	☐
	Learning disabilities	☐

LUNGS	Chest congestion or Productive chest cough	☐
	Asthma – wheezing or coughing spasms	☐
	Shortness of breath or Difficulty breathing	☐
	Recurrent or chronic bronchitis	☐
HEART	Irregular or skipped heartbeat	☐
	Rapid or pounding heartbeat	☐
	Chest pain	☐
HEAD	Headaches / Migraines	☐
	Faintness or light-headedness	☐
	Dizziness or vertigo	☐
	Insomnia or sleep disturbance	☐
SKIN	Acne	☐
	Hives, rashes, or dry skin, flaky scalp	☐
	Bumps or rough skin on the outer thighs or arms	☐
	Flushing or hot flushes	☐
	Eczema	☐
NAILS/	Hair Loss	☐
HAIR	Hair splits or breaks easily	☐
	Dandruff	☐
	Brittle nails	☐
	White marks on nails	☐
	Cracks on the sides of finger tips	☐
	Vertical ridges on nails	☐
JOINTS/	Pain or aches in the joints or arthritis	☐
MUSCLES	Pain or aches in muscles	☐
	Stiffness or limitation of movement	☐
	Feeling of weakness or tiredness	☐
	Muscle twitches or tremors	☐
ENERGY/	Fatigue, sluggishness or lethargy	☐
ACTIVITY	Apathy or Loss of motivation	☐
	Hyperactivity or Restlessness	☐
CHEMICAL	Sensitive/ reaction to perfumes, smoke, pollutants	☐
PROFILE	Regular or excessive contact with organic chemicals	☐
	(i.e. Insecticides, herbicides, petrochemicals etc)	☐
	Exposure to lead, mercury, copper or cadmium	☐
	Are you sensitive to food additives or preservatives	☐
	Excessive or long term antibiotic treatment	☐
	Do you have mercury fillings in your teeth	☐
OTHER	Recent illness or Recurrence of illness	☐
	Fluid or Water retention	☐
	Frequent or urgent urination	☐
	General itch or discharge	☐