



# HAHNEMANN CLINIC FOR HEILKUNST

## General Questionnaire – Children (12 and Under)

*The following information will be kept confidential and help us to help your child.*

**Full Given Name(s):** \_\_\_\_\_

**Surname:** \_\_\_\_\_

**Date of Birth:** (mm/dd/yy) \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_

**Time of Birth:** (local time, AM or PM, Time Zone, e.g., EST, PST, MST): \_\_\_\_\_

### **Physical Information** (SOC Index)

- \_\_\_ Number of organs removed
- \_\_\_ Number of synthetic drugs used currently
- \_\_\_ Number of steroid class drugs used in past year
- \_\_\_ Number of metal amalgam fillings currently or present in past year
- \_\_\_ Number of major allergies
- \_\_\_ Number of percentage of fat in diet (of calories – include processed foods)
- \_\_\_ Number of personal stress on scale of 1-10
- \_\_\_ Number of sugar-type products daily, including ice-cream, soft drinks, processed foods, etc.
- \_\_\_ Number of cups of caffeine, tea or caffeinated beverages daily
- \_\_\_ Number of extreme toxic exposures per year, incl. radiation, insecticides, chemicals.
- \_\_\_ Number of major injuries in the past.
- \_\_\_ Number of major infections, past and present.
- \_\_\_ Number of glasses of water or natural fruit juice per day.
- \_\_\_ Number of pounds over weight.

### **Diet/Nutrition**

My child is on the following diet:

- Gluten Free/Casein Free
- Specific Carbohydrate Diet
- Blood-type Diet
- Vegetarian
- Vegan
- Other: \_\_\_\_\_

For *Other*: Please describe what your child eats on a regular basis, or any particular diet they are on:

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**Food Cravings** (please list): \_\_\_\_\_

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**Appetite**

My child's appetite is \_\_\_\_\_

**Sleep**

Hours of sleep a night: \_\_\_\_\_

Kind of sleep (restful, sound, deep, refreshing, restless, fitful, light, etc.)?

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**Energy**

How would you characterize your child's energy level?

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Does your child have energy lows and highs during the day and if so, when? \_\_\_\_\_

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**Activity**

Is your child fairly active during the day, or more sedentary? \_\_\_\_\_

What kind(s) of activities does your child engage in and how often?

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**Stress**

Any fears?

Any phobias?

Any nightmares?



