Child Health Questionnaire

TREE OF LIFE WELLNESS CENTER, INC.

Name_____Age____DOB_____Weight____Date_____

Address_____
Street city/town State zip code

Telephone#_____Parent/Guardian_____

Reason for Appointment_____

Check off any symptoms that apply to your child (past or present).

Before Birth Symptoms

__Extreme over activity __Prolonged hiccupping __Vigorous kicking

Problems for mother or child with Pregnancy &/or Birth_____

_____

General Childhood Symptoms

__Prolonged colic __Excessive spitting __Nausea __Repeated vomiting __Diarrhea

__Anorexia/Bulemia __Constipation__Gas/Belching __Eczema __Psoriasis__Rashes

__Acne __Dry Skin __Dandruff __Brittle Nails__Dry Hair __Warts __Bed wetting

__Strong smelling Urine ___Bladder Infections __Red cheeks __Excessive drooling

__Head banging __Red Earlobes __Bad body odor __Fungal Infections__Herpes

__Dark eye circles__Bags under eyes or wrinkles __Eye discharge __Eye Infections

__Asthma __Allergies __Restless legs __Joint pain __Muscle cramps __Headaches

__Migraines __Grinds Teeth__Neck Pain __Back pain __Scoliosis __Shingles

__Chicken pox __Measles __Mumps __Roseola __Fifths Disease __Tubes in Ears

__Frequent colds __Chronic Congestion __Sore throats __Chronic Ear Infections

__Respiratory Infections __Sinus Infections __Excessive Bruising __Cold Sores

****

__Hyperactivity __Restlessness __Lethargic __Poor concentration __Spacey

__Impulsive __Short attention __Discipline problems __Depression __Irritability