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WELLNESS CHART

Please READ THIS FIRST before beginning to fill the form in

Welcome! To provide the best treatment , we need to evaluate your child's entire case by piecing together a complete profile and understanding all the features that make your child unique as an individual. The WHOLE is always the SUM of the parts.

To collaborate in treatment it is important to get to know all the details of their experience. This includes your reactions to various factors, physical sensations (what does it feel like), and function (how it impacts you) what makes it better or worse, your past and family history and your mental makeup. This information enables us to get a fuller understanding of how we work choose to work together. .

In order know all about you child, I will be asking you many questions. Each one of these questions has a definite meaning and significance. There is not a single question that is useless. Even something that you may think is not connected with their challenges, may be the most important factor in deciding the best course of treatment. That is why you must be free and honest and give the fullest possible information on each question and statement asked below.

Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you write or discuss will remain absolutely confidential. You will spend approximately 30 min. to an hour in this part of the process. Please be in touch if you have any questions.

THIS QUESTIONNAIRE HAS 3 PARTS:
About your past illnesses. Please take time to answer this part with the help of your family members before coming to your appointment.

1. Present and past history
2. Physical experiences
3. About your mental state and your emotional nature.

Today's Date: _____

Name: _____
Age: _____ Birth date:_____Sex: _____
Phone: (home)_____ (work)_____(cell)_____
Email:_____
(Please indicate preferred hours to reach you, at which number, and if it is appropriate for me to leave a message should it not be a private line/email address.)
Mailing Address:_____
_____
Live alone /
with:_____
Were you referred? If so, by who? If not, how did you hear?
_____
_____
Name of current General Practitioner (MD):_____
Last visit to your GP: _____
Reason for your last visit:_____
When was your last physical exam?_____
Are you seeing a medical specialist?_____
Specialist's name:_____
For what reason:_____
When was your last visit to the dentist?_____
Do you see another type of complimentary health practitioner and if so what kind and how often?_____
_____
_____

How would do you describe the issue or problem? _____

_____

How would you describe your child's general, overall state of health?
Excellent____ Good____ Fair____ Poor____

PREVIOUS DISEASES & DRUG USED

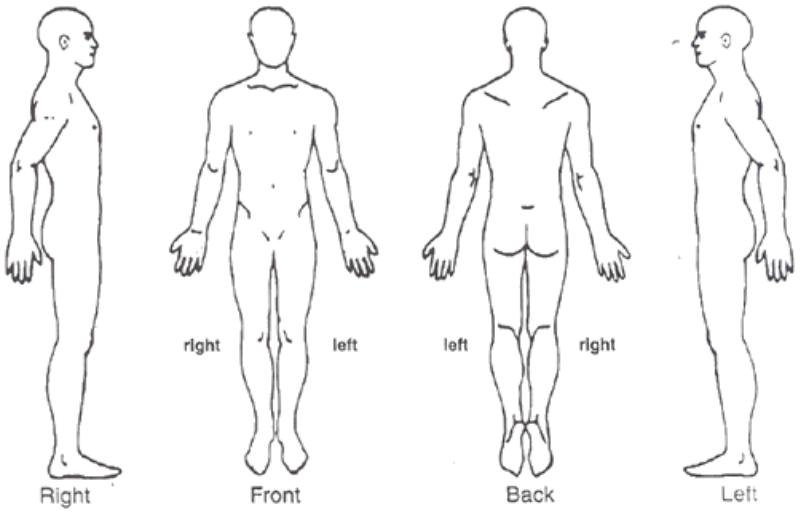
Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. The goal is to strengthen your body. Therefore, it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle or indicate below (if working remotely online) names of ALL major illness so far suffered and on the next page give its relevant details.

Typhoid Cholera Food Poisoning Worms	Measles German Measles Shingles Chicken-pos	Malaria Jaundice Any Liver Spleen or Gall bladder disease	Miscarriage Abortion Curettage (scraping of skin or internal surface for removing disease

Diarrhea Dysentery	Small-pox Mumps Whooping cough		tissue or obtain specimen) Sickness during pregnancy Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Venereal Diseases: Syphilis Gonorrhea Chlamydia Herpes H.I.V.	Heart Trouble: High/Low Blood pressure Heart Murmurs Palpitation Giddiness	Kidney or urine trouble Diabetes Prostate Cancer Prostatitis
Operations: Tonsils Abdomen Appendix Hernia Uterus Renal stones Gall stones Hydrocele Cataract Mode of Anesthesia: general-local	Diphtheria Septic Tonsils Adenoids Recurrent infections- Sinusitis Bronchitis Eosinophilia (in response to certain drugs, allergies, parasitic infestation)	Cold-Fever Chill Pneumonia Asthma Pleurisy T. B.	Serious shock, grief, disappointments, fright, mental upset, anxiety, depression or nervous break down.
Chronic Headaches Migraines Numbness Cramps Fits Convulsions Polio Paralysis Meningitis Any Lumbar Puncture	Major accident or injury to body or head Occasion of unconsciousness Major bleeding from any part of the body	Skin diseases: Acne Boils Carbuncles Eczema Urticaria Ulcers on any part of the body	Skin diseases (con): Ringworms Fungus Scabies Herpes -cold sores Allergy Unexplained rashes or bumps

Use the symbols to mark areas of concern.



● Pain / tenderness

▲ Numbness / tingling

⭘ Stiffness

■ Swelling

Comments:

_____

_____

_____

Were you on antibiotics for an extended period of time over the last ten years and if so, please explain when, why and for how long?

_____
_____
_____

Please list past: injuries, traumas, bites

_____
_____
_____
_____

Please list (as best you can) hospitalizations, surgeries, x-rays and other imaging scans that you've had along with the year in which they took place and what for.

_____
_____
_____
_____

Please check mark once if your child has or had any of the below qualities. Place two checks if the symptoms are more intense.

Quality	Check	Quality	Check
Obstinacy		Unusual Fears	
Temper tantrums		Shyness	
Disobedience		Unusual Attachments (to whom?)	
Aggression		Biting Nails	
Hyperactivity		Dullness of memory	
Destructiveness		Slowness (in what?)	
Possessiveness		Laziness/Indolence	
Competition - Winning Spirit		Sensitive/Emotional	
Sibling Jealousy			
Any Special Skills			
Unusual Desires (for what?)			
Stealing			
Telling Lies			

Please describe any other aspects you feel are striking about your child.

_____
_____

Describe one incident from the child's life when he/she was very upset. _____
_____

NUTRITION ASSESMENT

HT:	WT:

Weight History _____
Diet History _____
How is their appetite? _____
When are they hungry? _____
What happens if they have to remain hungry for long?
_____
How fast do they eat? _____
How much thirst do they have?
_____
Any particular times they are especially thirsty?
_____

24 Hour Recall/Typical Day

Breakfast:

Snack:

Lunch:

Snack:

Dinner

Please put one check mark if you Like/ Dislike the food or if the food disagrees. Put two check marks, if you strongly like / dislike the food or if the food strongly disagrees.

Taste	Like	Dislike	Disagrees
Bitter			
Extra Salt			
Sweet			
Sour			
Bread			
Butter			
Fats			
Milk			
Coffee			
Eggs			
Spicy Food			
Meat			
Fish			
Warm Food/Drink			
Cold Food/Drink			

STOOL

Do they have any problem with their stools? Yes/No If yes, please explain.
_____
_____
When and how many times a day they pass stools? _____
When is it urgent? _____
Do they have to strain for stool? _____
Even if soft? Yes/No

SWEAT / PERSPIRATION - FEVER - CHILL

How much do they sweat? _____Where and on what part of the body do they sweat most? _____
Do they perspire on the palms or soles? Yes/No
Do they experience any sense of heat or cold in any part of their body at any particular time?
_____

CHEST - HEAT - COLD - COUGH

Is there any trouble with their CHEST or HEART? Yes/No_____
Is there any difficulty in breathing? Yes/No _____

FOR MENSTRUATING WOMEN

Menses: How are your periods; regular or irregular? _____
At what age did you start? _____
Was there any trouble then? _____
Timing between two periods. _____ Number of days of flow. _____
Menstrual flow: Is there any change now in quantity, color, smell or consistency?
_____
_____
Clots?_____
_____
Do you suffer in any way before, during or after menses?
If so, describe. _____

VERTIGO - Do you have dizziness - vertigo? Yes/No
Do you ever feel faint? Yes/No
HEAD - Do you get headaches? Yes/No Migraines? If yes, please describe from start
_____
_____
_____
EYES & VISION?_____
EARS & Sense of hearing?_____
NOSE & Sense of smell? _____
FACE & Facial
expression?_____

MOUTH & Sense of taste? _____
LIPS : Cracked, peeling of skin

_____
TEETH, GUMS, carious teeth, bleeding gums. swollen gums.

_____
THROAT (including tonsils): _____
Any difficulty in swallowing? Sensations?(eg. a lump, hair or splinter)_____
Do THEY have any trouble in your BACK, LIMBS OR JOINTS?
Describe_____

_____

_____
Is Are there any senses of weakness? Where? _____
When is it more or less? _____
Is it in any particular part of the body? _____

FACTORS THAT AFFECT YOU

Below are lists of things that you are exposed to each day that may affect you in a particular way. Please write in how you are affected by each of the below items. Do you feel worse or better in any way from each of the factors. In what way do they affect you. For instance, take the factor “sun”. Suppose by going in the sun you get a headache then write “Headache” opposite to “Sun”. Take another example, if in hot weather you feel uneasy, then write “Uneasy” opposite to “Hot Weather” in the column.
In this way, write the effect of each factor on you. Especially write the effect each factor has on your chief complaints. For instance, if your chief complaint is asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes worse”. Sometimes one factor may make you feel worse in some respect, and better in some other respect. For example, cold air may cause a headache but make you feel better in general. If this is so, please mention this difference clearly.
This section is **extremely important** when evaluating. Do not go through it rapidly and be sure to **take your time** with each item. **Think carefully** about the effect of each factor **before** you make a **comment**.

Factor	Effects	Factor	Effects
Hot weather		going to school	
cold weather		hanging out with friends	
rainy weather		before bed	
cloudy weather		before exams	
change of season		laughing	
thunder storm		talking	
climbing stairs		reading	
warm bath		writing	
sun		sitting	
Lying down		before important engagement	

MIND

Your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole. In order to understand you I will be asking questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental makeup. There is no judgment, right or wrong. Answer freely, frankly and completely.

Are they anxious? About which matters?

_____

Are they fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.?

_____

Are they doubtful or suspicious? Of what?

_____

What are you proud of? _____

Experiences of depression, brooding, etc.?

_____

Have they ever become suicidal?

_____When?_____ _____

When are they cheerful? _____

Any unwanted thoughts any time? Yes/No_____

Do they weep easily? _____What makes them weep?

_____

_____

How do they respond if someone offers sympathy and consolation?

_____

Are they easily irritated? Yes/No What makes you angry?

_____

Where would you place the level of personal stress you are experiencing right now?

Minimal Average Considerable Intolerable

The main stressor:

What "triggers" a stress response in your child_____

_____

If asked for 3 desires or wishes in life, what will you ask for?

_____

_____

_____

ASK YOUR CHILD TO FINISH THESE STATEMENTS

What makes no sense at all about me is_____
_____
I should_____
_____
The repeated thoughts/overplayed tapes in my head are_____
_____
The story of my life right now is..... the title of my biography would be_____

I have never been the same since_____
In what sense?_____
Favorite song, quote, or memory?
_____
_____

What do people tease you about? _____

SLEEP

Describe their posture in sleep, on the back, side, abdomen, etc.
_____
Are they able to sleep in any position? Yes/No In which position can't they sleep and why?
_____

How long does it take them to fall asleep?_____
Do they wake often in the night? Particular
time?_____
Do they wake feeling rested?_____
Average number hours of sleep? _____

Recurring dreams at any period in or throughout your life or particular theme?
_____
_____
_____