Benjamin McAvoy
The Healer Medium

Child

The Healer Medium
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Name: _____ DOB: _____

Parent/guardian name/s: _____

Address: _____

Phone: _____Email:_____

Name/s and age/s of siblings:
_____

Height: _____ Weight: _____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reason for your appointment and other current health concerns:

1. _____
2. _____
3. _____

Recent pathology/tests/investigations/operations etc:
_____
_____
_____

Current medications (including dosage):
_____
_____
_____

Current supplements (dose and brand):
_____
_____

Please list any health concerns of family members including siblings, parents and grandparents:
_____
_____
_____
_

Please list any previous medical history:
_____
_____
_____

Please explain your child's general temperament:
_____
_____
_

Has your child taken any antibiotics? If yes, when and how many?
_____
_____

Did you experience any pregnancy complications?
_____
_____

☐ What was your child's birth weight?
_____

☐ Was your child breastfed? Exclusively? _____How long? _____
☐ Was your child formula fed? Which formula?
_____

Birth details:

☐ Vaginal delivery
☐ Caeserean section
☐ Forceps delivery
☐ Vacuum extraction
☐ Foetal distress
☐ Low birth weight
☐ Premature delivery
☐ Prolonged labour

Early development:_____

What age were solids introduced? _____

What age was your child toilet trained? _____

Were milestones achieved on time? _____

General Health Questionnaire:
Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if your child has never experienced this symptom.

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux
- ☐ Colic
- ☐ Burping
- ☐ Nausea
- ☐ Daily bowel movements
- ☐ Irregular bowel movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fussy eating
- ☐ Stomach aches
- ☐ Poor appetite
- ☐ Difficulty gaining weight
- ☐ Recent weight gain

☐ Food intolerances. Please list:

_____

_____

_____

- ☐ Headaches
- ☐ Sleeping problems
- ☐ Night terrors
- ☐ Bed wetting
- ☐ Clingy
- ☐ Difficult to settle

- ☐ Excessive whinging
- ☐ Anxiety
- ☐ Mood swings
- ☐ Poor concentration / focus
- ☐ Socially withdrawn
- ☐ Tantrums

- ☐ Recurrent colds and flu
- ☐ Hayfever / sinusitis
- ☐ Asthma
- ☐ Slow wound healing
- ☐ Sneezing, coughing, wheezing
- ☐ Eczema or skin rashes
- ☐ Itchy eyes, ears, nose, throat, skin

- ☐ Waxy ears
- ☐ Cradle cap
- ☐ Dry skin

Additional information:

_____

_____