Truly You Holistic Health Clinic

Children (12 and Under) Intake Questionnaire

Full Given Name: ____

Date of Birth: (mm/dd/yy) ________________ **Place of Birth**: ____________________________

____________________________________ ______________________________________
Mother's Name **Father's Name**

____
Address

__________________________________ ____
Home Phone Number **Alternate Contact Number**

Physical Information:

____ Number of organs removed, please list:____
____

____ 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 please list:____
____
____

____ 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 please list:_____________________________________
____
____
____

____ Number of major infections, past and present please list: ____________________________
____
____
____
____
____
____
____

____ Number of glasses of water per day
____ Number of glasses of natural fruit juice per day.
____ Number of pounds overweight. Current weight: __________lbs

Diet/Nutrition

My child is on the following diet:
o Gluten Free/Casein Free
o Specific Carbohydrate Diet

o Blood-type Diet
o Vegetarian
o Vegan
o Other: ____

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

Food Cravings (please list): ____
____

Appetite
My child's appetite is ____
____

Sleep
Hours of sleep a night: _________ What is your child's bedtime:____________
Kind of sleep (restful, sound, deep, refreshing, restless, fitful, light, etc.)?
____
____
____

Does your child nap? _____________ If yes, length and quality of nap:________________________
____
____

Energy
How would you characterize your child's energy level?
____
____
____

Does your child have energy lows and highs during the day and if so, what time? _______________
____

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?
____
____
____

Stress
Any fears?____
Any phobias?____
Any nightmares?____

Nutritional Supplements
Please list any specific nutritional supplements (e.g., greens, vitamins, probiotics, power bars, drinks, etc.) your child takes regularly: ____
____
____
____

Drugs and Herbs

Please list all prescribed and over-the-counter *drugs* that your child is currently on:

Please list all *herbal products* your child is currently taking:

Current Medical/Health Concerns

Please describe any and all medical/health issues your child has currently, such as allergies, digestion, skin, lung, etc. problems, conventional diagnoses, behavioural issues, recurrent infections, physical pains, organ dysfunctions, etc.

Primary Concern:

Please explain your reason for starting your child in treatment, and your expectations and goals:

Miscellaneous

Please provide any other information about your child that you think we should know or that might be helpful to us in providing treatment.

Immunization History

Have you/your child received the following vaccinations? Please check those that apply.

Type	2 months	4 months	6 months	18 month	18 month	4-6 year	14-16 years	Boosters
Diphtheria	☐	☐	☐	☐	☐	☐	☐	☐
Pertussis	☐	☐	☐	☐	☐	☐	☐	☐
Tetanus	☐	☐	☐	☐	☐	☐	☐	☐
Polio (IPV)	☐	☐	☐	☐	☐	☐	☐	☐
Polio (OPV)	☐	☐	☐	☐	☐	☐	☐	☐
Hib	☐	☐	☐	☐	☐	☐	☐	☐
Measles	☐	☐	☐	☐	☐	☐	☐	☐
Mumps	☐	☐	☐	☐	☐	☐	☐	☐
Rubella	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐	☐	☐	☐	☐
Chicken Pox	☐	☐	☐	☐	☐	☐	☐	☐
Meningitis	☐	☐	☐	☐	☐	☐	☐	☐
Influenza	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐	☐	☐	☐	☐

Please indicate any reactions to immunizations: ____

Family History

Please indicate which family members have had, or who currently have the following conditions:

Condition		Condition	
Alcoholism	☐	Cancer	☐
Allergies	☐	Cataracts	☐
Arteriosclerosis	☐	Celiac Disease	☐
Arthritis	☐	Crohns/Colitis	☐
Asthma	☐	Depression	☐
Bed wetting	☐	Diabetes	☐
Birth Defects	☐	Epilepsy	☐
Blindness	☐	Osteoporosis	☐
Heart Disease	☐	Ulcers	☐
Hyperactivity	☐	Stroke	☐
Kidney Disease	☐	TB	☐
Learning Disability	☐	Yeast Infections	☐
Mental Illness	☐		☐
MS	☐		☐
MD	☐		☐

Consent to Treatment

I, _________________________hereby consent to Heilkunst treatment of myself/my child _________________________ by Doctor of Medical Heilkunst and Homeopathic Doctor, Roxanne Harris DHHP, DMH, DynNC, DynBC. I voluntarily consent to diagnostic and therapeutic procedures including physical, mental, emotional, and spiritual aspects, except for the following _________________________. I understand that the Heilkunstler may not be able to anticipate and explain all risks and complications resulting from treatment and understand that expected results cannot be guaranteed.

Office Use Only _________________________
mm/dd/yy Signature

_________________________ _________________________
mm/dd/yy Signature of Witness

_________________________ _________________________
mm/dd/yy Signature of Heilkunstler

Blood Type	
Glandular Type	
Metabolic Type	
Constitutional Type	
Office Use Only	

Treating DMH _________________________
Please Print Full Practitioner's Name

Date of Initial Intake Interview _________________________ Signature _________________________
mm/dd/yy mm/dd/yy

Date File Closed _________________________ DMH/DHHP _________________________
mm/dd/yy mm/dd/yy

For Office Use Only