Children's Health Evaluation Questionnaire

Please take the time to carefully complete this questionnaire as fully as possible and **bring the completed form with you to your child's first appointment**. In order to assist your child to get better, it is important to get the whole picture of their health, rather than just look at the obvious symptoms. It will also save time during the consultation. Please answer all questions as best you can, and don't worry if there's anything you are not sure about or you can't remember.

Child's name: Your name: Your relationship to child (eg parent/guardian):		Today's date: Child's birth date: Child's age:	How did you hear about us? (*If someone referred you, who was it?)*
Address: Postcode:		Your contact details: Mobile: Home: Work: Email:	
Your Occupation:	Partner's Occupation:	Do you have other children? (names & ages):	

What is the main reason for your visit? (Please be specific and detailed - include the history of the issue and what has been done about it so far):
Are there any secondary issues that you would like to mention?
Please outline your child's health history (Past issues, dates, treatment used etc.)
Are there any hereditary diseases or disorders in the family? (e.g. diabetes, cancer etc)
Does your child have a contagious infection at present? (if yes, please give details) ***Please let us know before your appointment if they do***
Has your child had surgery? (If yes, please give details)

Has your child suffered any trauma or grief? (If yes, please give details)
Has your child ever been bitten by a tick? (If yes, please give details)

Current medications your child is taking			
Name	Dosage	For what condition	Since when

Current natural health products/supplements your child is taking			
Name	Dosage	For what condition	Since when

Has your child had any of the following medication in their lifetime?		
Name	Yes or No	How many times and for how long?
Antibiotics / Penicillin		
Painkillers (e.g. paracetamol & ibuforen)		
Steroidal anti-inflammatories (e.g. inhalers / skin creams)		
Anaesthetics		

Please rate the following out of 10 (where 1 is very poor and 10 is excellent)	
Your child's general overall health, wellness and resiliency	
Your child's general immunity or immune resilience	
Their general level of energy	
The quality of their sleep	
Please rate your child's stress levels (where 1 is low and 10 is very high)	

DOES YOUR CHILD HAVE ANY PROBLEMS OR ISSUES WITH ANY OF THE FOLLOWING BODY SYSTEMS:

Circle (or mark with an 'X' if completing the form online) the extent to which they experience the following symptoms**, leaving blank any that they do not experience**.
Scale: 1 means they seldom experience it and 5 means it is troublesome to them most of the time.

Digestion

1	2	3	4	5	Abdominal bloating
1	2	3	4	5	Metallic taste in mouth
1	2	3	4	5	Mouth ulcers
1	2	3	4	5	Poor digestion
1	2	3	4	5	Poor sense of taste
1	2	3	4	5	Bleeding gums
1	2	3	4	5	Sores at corners of lips

Bowel

1	2	3	4	5	Loose stools
1	2	3	4	5	Diarrhoea
1	2	3	4	5	Constipation
1	2	3	4	5	Bowel urgency
1	2	3	4	5	Flatulence
1	2	3	4	5	Undigested food in stools
1	2	3	4	5	Irritable Bowel Syndrome

Urination

1	2	3	4	5	Scant urination
1	2	3	4	5	Strong smelling or dark yellow urine
1	2	3	4	5	Kidney problems
1	2	3	4	5	Urinary tract infections
1	2	3	4	5	Burning pain

Nervous System

1	2	3	4	5	Headaches
1	2	3	4	5	Migraines
1	2	3	4	5	Numbness/tingling
1	2	3	4	5	Epilepsy
1	2	3	4	5	Easily stressed

Circulation System

1	2	3	4	5	Anaemia
1	2	3	4	5	Easy bruising or bleeding
1	2	3	4	5	Ringing in ears
1	2	3	4	5	Surface veins
1	2	3	4	5	Racing pulse
1	2	3	4	5	Irregular heartbeat
1	2	3	4	5	Dizziness
1	2	3	4	5	Cold feet
1	2	3	4	5	Heart valve issues
1	2	3	4	5	General weakness of the heart

Mood/Emotions

1	2	3	4	5	Anxiousness
1	2	3	4	5	Depression
1	2	3	4	5	ADD/ADHD
1	2	3	4	5	Melancholy
1	2	3	4	5	Aggressive behaviour
1	2	3	4	5	Irritable
1	2	3	4	5	Angry
1	2	3	4	5	Agitated
1	2	3	4	5	Withdrawn
1	2	3	4	5	Oppositional defiance

Hormones

1	2	3	4	5	Hormonal problems
1	2	3	4	5	Hypo/hyper thyroid
1	2	3	4	5	Growth problems
1	2	3	4	5	Adrenal problems
1	2	3	4	5	Undescended testes
1	2	3	4	5	Period problems
1	2	3	4	5	

Bones/Muscles

1	2	3	4	5	Bone breaks or fractures
1	2	3	4	5	Rickets
1	2	3	4	5	Bow legs
1	2	3	4	5	Pigeon toes
1	2	3	4	5	Cavities
1	2	3	4	5	Muscle pain/strain
1	2	3	4	5	Cramps

Skin

1	2	3	4	5	Eczema
1	2	3	4	5	Dermatitis
1	2	3	4	5	Rashes
1	2	3	4	5	Psoriasis
1	2	3	4	5	Itching
1	2	3	4	5	Urticaria (hives)
1	2	3	4	5	Blotchiness
1	2	3	4	5	Nappy rash

Immune/Respiratory System

1	2	3	4	5	Frequent colds/sore throats
1	2	3	4	5	Runny nose
1	2	3	4	5	Hayfever
1	2	3	4	5	Sinusitis
1	2	3	4	5	Asthma
1	2	3	4	5	Ear infections
1	2	3	4	5	History of pneumonia
1	2	3	4	5	History of glandular fever

Has your child had any of the following diseases/conditions (tick if yes)	Tick here	Please describe your child's stools (tick any that apply)	Tick here
Chicken pox		poorly formed	
Mumps		bitty	
Measles		narrow, thin & unformed	
Slap cheek		mucous containing	
Hand/foot/mouth		light coloured	
Roseola		dark coloured	
High temperatures		floating	
Whooping cough		odorous	
Bronchitis		hard & dry	
Bronchiolitis		sticky or messy	
Tonsillitis		difficult to pass	
Ear infections		an event(!)	
Staph infection		well formed & easy to pass	
Perforated ear drum			
Fluid on the ear			
Any gastrointestinal infections requiring antibiotics or other treatment (please give details):			
Have they ever visited a country where they could have picked up a gut bug? (please give details):			

What vaccinations has your child had and at what age (eg at birth, 8 wks, 12 wks, 4yrs)

Vaccination	Age	Any other vaccinations (please give name)	Age
Vitamin K			
Hepatitis B			
Rota Virus			
Diptheria-Tetanus-Whooping Cough			
Hib Type B			
Hib/Men C			
Polio			
Pneumococcal disease			
Measles-Mumps-Rubella			
Meningococcal C disease			
Meningococcal B			
Did you notice any changes in your child after any vaccinations?			

DIET

At what age did your child start to eat the following:	**Age**	**Do they have any Allergies, Intolerances or Sensitivities to anything that you know of? (ie: foods, lactose, casein, wheat, gluten, dust, medications or other substances):**
Solids generally		
Wheat (bread, pasta, cereal, crackers, biscuits etc)		
Dairy – yogurt, milk by the glass, cheddar cheese		
Eggs		
Chocolate		
Sweets/sugar		
Juice		
Nuts - what kind?		

Are you or your child vegetarian?		**ARTIFICIAL SWEETENERS:** What **'SUGAR FREE'** FOODS OR DRINKS does your child have – now or in the past? (900 numbers: please check the labels of the foods in your pantry or fridge)	
If yes, how long?			
Please tick which applies below:			
Vegan (no dairy or animal products)		Sugar-free cordial	
Ovo Lacto (dairy & eggs are ok)		Soft drink	
Semi–vegetarian (no meat, but do eat fish)		Juices	
Other		Jelly	
		Yogurt	
		Extra gum	
		Chewing gum	
		Sweets	
		Ice cream	
		Other	

DRINKS and SWEETS			**DAIRY**		
	How much/many per day?	**What type?**		**How much per day?**	**What type?**
Water			Milk		
Juice			Yoghurt		
Milk by the glass			Cheese		
Soft drink			Ice cream		
Tea			Custard		
Coffee			Dairy-based		

			dessert		
Herbal tea			**OTHER FOODS**		
Sweets and chocolates			Nuts		
Cake and biscuits			Bread		
Crisps			Spreads or sandwich fillings		

How much **sugar** would your child have in a day? (describe sources and guesstimate how many teaspoons it would contain: 1 teaspoon = 5g of sugar)
Do you or they spoon sugar onto food (e.g. cereal) or into drinks? If yes, please give details:
How many servings of protein does your child have **per week?** (e.g. eggs, fish, beef, chicken):

Please give an example of your child's typical day's food and drink intake:			
BREAKFAST	**LUNCH**	**SNACKS & DRINKS**	**DINNER**

YOUR HOME

Do you have wireless internet?	
Where does the power box / smart meter connect to your home?	
Do you have solar panels? What room/s are they above and when were they installed?	
Do any of the rooms have visible mould on the walls / tiles / ceiling?	
Does your home smell damp or mouldy? (Best to ask a person who doesn't live there)	
How much time per week does your child spend on a tablet/ smart phone / computer / other digital media?	
How much full body sunshine does your child get in a week without wearing sunscreen?	

If your child is under 5 years old, these are questions to be answered by the birth mother (if possible):

How was your pregnancy with this child? (e.g. easy/ moderately troublesome/difficult):
Did you have any vaccinations or medications during your pregnancy or in the twelve months prior to conception?
How long was your labour in total?
Were you induced? If yes, how & at how many weeks?

LABOUR:		**POSTNATAL ILLNESSES**	
Did you have any of the following (tick which apply)	**TICK**	Did you or the baby have any of these illnesses in the year after birth?	**TICK**
Vacuum extraction		Whooping cough	
Caesarean –Emergency		Bronchiolitis	
Caesarean - Elective		Measles	
Epidural		Mumps	
Pethidine		Chicken pox	
Gas (Nitrous oxide		Gastritis	
Water Birth		Giardia	
Syntocinon to deliver the placenta		Pneumonia	

Informed Consent for Bioresonance Naturopathic Treatment

I accept the Bioresonance and Naturopathic treatment provided by the below named practitioner.
I understand that:

- Bioresonance diagnosis and treatment, and Naturopathic examination and treatment, are not a substitute for medical examination and diagnosis.
- it is recommended that my child sees or continues to see a medical doctor (for any physical ailment for which I seek Bioresonance and Naturopathic treatment) if guided to do so by my practitioner.
- the results of Bioresonance testing must always be interpreted while taking into account my medical history, physical attributes, laboratory readings and other results, and this in no way replaces the need for conventional diagnosis. I understand that the Bioresonance test results are particularly important for the resulting energetic therapy with Bioresonance, and that more information can be found on the website: jennyblondel.com
- changes may be made to the treatment along the way to serve a better outcome.
- Bioresonance and Naturopathy have been used safely for many years and can have the effect of normalising physiological functions, and that, on rare occasions, untoward effects may occur.
- despite the best intentions of the practitioner and my child, there may be unresolved symptoms, and that improvement of (all) symptoms is not guaranteed.
- all my child's records will be kept confidential and will not be released without my consent.
- a specific time is allocated for my child's appointment and should I arrive late with my child (for whatever reason) they may not receive the full allocated time. I also understand that if we cannot keep the appointment, I am responsible for notifying the Ilkley Healing Centre of the cancellation at least 36 working hours in advance. Otherwise I accept I will be charged the full fee.

I have read, or have had read to me, the above consent, and by signing below I am indicating understanding of the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature:	**Date:**
Signature of Parent/Guardian for children under 18 years	
Name of practitioner	
Signature of practitioner	