

**Child’s Health Profile Date of consultation**

Hello and Welcome from Orange Health. You can forward this document to yourself in order to edit, save and return to us or print and complete. Please complete the following on behalf of your child and post, scan, fax or email back. Highlight any conditions that are relevant about your child, we will discuss the detail further during the consultation. Please let us know if there is any information you would rather not be discussed in front of you child. Please return profile to us before your appointment. Thank you.

Top of Form

Name of child Date of Birth Sex

Age    Nationality

Address

Phone Mobile Email (parents)

Childs weight Parents names

Name of GP

Has your child seen a Naturopath or Herbalist before?

Please note where you heard about us from please.

**List the health issues you would like to address and how long your child has had them (we will go into more detail at your consultation)**

**1/**

**2/**

**3/**

\*\*Please note the 1 best outcome for your child ie your treatment focus

###### Family History (who has these conditions)

Arthritis, Heart Disease, Diabetes, Cancer, Parkinson’s, Alzheimer’s, Epilepsy, Dementia, Mental Illness, or other family history?

Has your child ever used reflux treatment ie losec, omeparazole?

List any medication or supplements taken now

**\*\*Important note \*\***

**For all the following categories 1- 6 please highlight or underline any conditions that your child has has on a regular basis or has been a problem in the past.**

**1: Childs Health History**

Chemical reactions / Tropical disease / Chronic Fatigue / Rheumatic fever / Childhood diseases (only mention if very ill) / Psychiatric disorders / Jaundice / Hepatitis / Glandular fever / Immunisation reactions / Cancer / Tumors / Cysts / Appendicitis / Eating disorders Wind / Reflux - Any other medical conditions? (please specify)

#### 2:Respiratory System

Asthma / Lung complaints / Grommets / Ear ache / Ear infections / Glue ear /Post nasal drip / Sore throat / Hay fever / Sinus / Wheeze / Chest infections / Constant cough or Runny nose / Snoring / Nose bleeds / Recurrent colds and flu’s

Do you live near a golf course, farm, orchard

Is your child exposed to garden sprays / hair dressing chemicals / spa pool chemicals / fly spray / plug in air fresheners / painting or renovation / plug in repellants / vodaphone or telecom towers / overhead high tension wires / pylons / power transformers / air conditioning / tank water / Do you have smart meter in you home? Please list electronic devices your has in your bedroom ie TV, computer, radio, alarm clock

**3:Stomach and Bowel**

Diarrhea / Constipation Bowel movements (how often)

Indigestion / Colic Weight issues

Heart burn / Reflux Bloating / Ulcers

Flatulence / Burping / Rectal bleeding Nausea / Vomiting

Rectal itching / Worms Bad breath

Root canals / Amalgam fillings Candida / Thrush / Yeast infections

Unexplained sore tummy's

Do the childs parents or siblings have food allergies or intolerances? is so what are they or what are your suspicions?

#### 4:Urinary System

Strong colour / Strong smell / Cystitis or kidney infections / Bed wetting

#### 5:Nervous System

Grind teeth / Dreams or nightmares / Poor memory / Headaches / Migraines / Cramps Twitches / Hearing loss / Tinnitus / Eye disorders / Dizziness / Vertigo / Numbness or tingling / Excess sweating / Difficulty sleeping / Especially competitive / Perfectionist Behavioural issues / ADHD / Autism

#### 6:Skin

Rashes / Fungal / Warts / Moles / Mouth ulcers /Cold sores / Shingles / Boils

Lesions / Dry scaly patches / Bruise easily /Psoriasis / Dermatitis / Eczema / Dandruff Cradle cap / Dry skin / Oily skin

**General**

* Antibiotics (when was the last time used and what for?)
* Approx how many times on antibiotics in your childs life?
* Milk Formula (when started and what sort used ie cow, goats, soy)
* Natural birth or caesarean?
* If breast fed - how long for?
* What age was food introduced?
* What foods did your child start with?
* When was the last vaccination given?
* Bed wetting problems?
* What animals live in the home?
* Is your child sensitive, tearful, emotional, angry, aggressive?
* Does your child make friends easily?
* Any particular issues mentioned by teachers?
* Where is the power meter box in relation to your child’s bedroom
* Is there a TV, stereo or fridge behind the wall of your child’s room?
* Has there been any major change at home or in your child’s life recently?
* Where there any complications during pregnancy or delivery and or was the child’s mother on any medication, antibiotics, alcohol or drugs during pregnancy?
* Please note any other information that may be useful.

How many glasses or cups of the following does your child drink a day?

Water Milk Milo or Cocoa Herbal tea

Coffee Fizzy drinks Cordial Breastfed Other

Please answer the following questions on behalf of your child

How many teaspoons of sugar added daily to drinks or on cereal ?

margarine or butter use?

brown or white bread?

Is your child a vegetarianYes / No

Does your child have a sweet tooth Yes / No

Or salt preference Yes / No

Does your child use sweeteners Yes / No

Does your child have a good appetite Yes / No

Does your child always have breakfast Yes / No

Is your child **wheat**, **gluten** or **dairy free**? Yes / No (if so please note which ones)

Do you have any suspicions what foods upset your child?

Does your child have any other food allergies or intolerances? (Please note)

What sort of exercise does your child do and how often?

**Please list what your child would usually have for breakfast, lunch and dinner. Give as much detail as possible ie ham, 2 minute noodles, butter, mayonnaise, full milk, soy milk…**

**Breakfast**

**Snacks**

**Lunch**

**Dinner**

Do you consider your child’s diet to be (Poor) (OK) (Very Good)

If you have already decided you would like to go ahead with the following services please note here.

* Food allergy / intolerance test via a hair sample –

(please provide plenty of dietary detail above as this will be necessary information to accompany the hair analysis to the lab thanks)

**Please bring to your appointment**

Any blood tests you have had done in the last 3 months. Just ask the doctors receptionist to post a copy to you or me, or they can fax to 04 801 7523

Please return this completed health profile to [orangehealth@orangehealth.co.nz](mailto:info@orangehealth.co.nz) before your appointment. Thank you and look forward to seeing you. Be in touch if you have any questions on 04 801 7520.

Please note it is valuable for you to have someone accompany you to this appointment to help with your child as there is a lot to discuss and understand thanks.

**Physical address**

181 Willis Street (ground floor on right of front stairs)

Anzac House (Opposite St John’s Church)

100m from Wilson Car park building

Street parking in Dixon & Willis St ($4 per hour)

Parking in Dixon & Willis St ($4 per hour)