HEALTH APPRAISAL QUESTIONNAIRE

Complete this form to the best of your ability.
If you have current lab results (SMA, CBC/with diff or Thyroid work T3, T4, T7, TSH)
or other information you feel would be helpful, please attach

Today's Date _____

Client's Name _____ Date of Birth _____

Parent's/Guardian's Name _____

Address_____ Telephone Home _____-_____-_____

City _____ Work _____-_____-_____

State _____Zip Code _____ Fax _____-_____-_____

Country _____ E-mail _____

Occupations of parents/guardians _____

Names and ages of brothers and sisters _____

_____

Who spends most of the time caring for the child? _____

Are you a NACD family? yes/no If yes, who did your last evaluation? _____ Location _____

Place of Birth (home/hospital) _____ Birth Weight _____

Current Weight _____ Gaining, losing or steady? _____

Current Height _____ Sex male/female

Confirmed Medical Diagnosis _____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined by	Diagnosis	Recommendations

Seizures? yes/no

Frequency of Seizures _____ Length _____

Type(s)_____

Currently taking seizure medication? yes/no

List medication(s)_____

Seizure medications taken previously? yes/no

List medication(s)_____

Currently taking other medications? yes/no

List medication(s)_____

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Sensitivity to foods, textures, tastes, odors, etc.?yes/no

List _____

_____

Describe the client's diet _____

_____

_____

	Excessive	Daily	Weekly	Rarely	Never
vegetables	_____	_____	_____	_____	_____
fruits	_____	_____	_____	_____	_____
meats	_____	_____	_____	_____	_____
sugar	_____	_____	_____	_____	_____
artificial sweeteners	_____	_____	_____	_____	_____
artificial colorings	_____	_____	_____	_____	_____
dairy products	_____	_____	_____	_____	_____
white flour	_____	_____	_____	_____	_____
tobacco	_____	_____	_____	_____	_____
alcohol	_____	_____	_____	_____	_____

Does the client chew their food well? yes/no

Describe _____

List dietary supplements and vitamins _____

_____

_____

Food allergies? yes/no/never tested

Food cravings?	yes/no	Overeats?	yes/no
Poor appetite?	yes/no	Picky eater?	yes/no
Other allergies?	yes/no		

If yes, please describe_____

Immunizations/inoculations (age received):

DPT _____	Tetanus_____	Smallpox _____	Measles _____
Mumps _____	Rubella _____	Polio _____	HIB _____
Chickenpox _____	Other _____		

What are your primary concerns and goals? _____

_____

_____

_____

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If the child's mother had any of these problems during her pregnancy with this child check YES. If unsure leave blank.

yes no

- high blood pressure
- diabetes or sugar in urine
- albumin or protein in urine
- urinary infection
- German (3-day) measles
- Gonorrhea or syphilis
- drug or drinking dependence
- frequent cigarettes
- other problems or treatment for illnesses

_____
_____
_____

yes no

- was prenatal care received before the sixth month of pregnancy?
- was this child born premature?
- was the birth difficult?
- was the baby born with forceps, caesarean, bottom first? (circle)
- did the baby have problems at birth or need help to start breathing?
- did the baby remain in the hospital longer than mother
- was the baby breastfed?
  Until what age _____

MEDICAL HISTORY

If this child has ever had the following problems check YES, if unsure leave blank.

yes no

- Asthma
- Blood disorders
- Chicken Pox
- Convulsions or fits
- Croup
- Eczema
- Frequent bronchitis
- German measles (3-day)

yes no

- Hospitalization or operations
- Measles (10-day)
- Mumps
- Pneumonia
- Rheumatic fever
- Scarlet fever
- Whooping cough
- Worms

If your child has ever been bothered with any of the following problems check YES.

yes no

- frequent headaches
- eye irritation
- eyes crossing
- trouble with vision
- wears glasses

- earaches or running ears
- difficulty hearing
- pulling or tugging his/her ears
- speech impediment

- dental problems
- sore or bleeding mouth or gums

- frequent colds
- mouth breathing
- recurring nosebleeds

- recent sore throat
- hoarse voice

yes no

- pain or crying when urinating
- brown, black, or bloody urine
- bedwetting (over 4 years old)
- daytime wetting (over 3 years old)
- discharge from penis or vagina

- marked increase or decrease in appetite
- weight loss or gain
- rashes or swellings after eating certain foods
- hay fever or allergies in spring, to animals, etc.
- skin rashes or swelling
- itching skin
- warts
- bruises or bleeding problems
- accidental poisoning
- listless or tired
- recurrent fevers
- motion sickness
- serious accidents, sprains, broken bones

- shyness

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yes no

- wheezing or gasping
- coughing spells
- shortness of breath while walking or play
- must squat or hunch down often while playing
- chest pains

- burping or gas
- abdominal pain
- vomiting
- diarrhea
- constipation
- itching at anus
- blood with stools
- must have a special diet
- frequent urination

yes no

- frequent nightmares
- waking often during night
- fears
- overly clinging
- easily upset, crying
- temper fits
- breaks or throws things
- fighting
- stealing
- lying
- nervous or nervous habits
- special school or classes
- problems at school
- problems with the family

Additional comments or special problems: _____

_____

_____

_____

_____

Place an (x) in the appropriate column for any illnesses that this child's blood relatives have had. Briefly describe the condition under comments.

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brothers or Sisters	Comments
Allergies						
Anemia						
Arthritis						
Asthma						
Bleeding Problems						
Cancer or Tumors						
Diabetes						
Digestive conditions						
Drinking or drug problems						
Epilepsy/convulsions						
Genetic diseases						
Headaches						
Heart disease						
High blood pressure						
Kidney disease						
Mental illness						
Respiratory illnesses						
Skin conditions						
Thyroid problems						
Tuberculosis						
Venereal disease						
Other major illnesses						

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