Nicholas Mazzoli

Homeopathic Practitioner

Date:

Health History Questionnaire - Children

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Patient Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Mother's Name	**Daytime phone**	
	Evening phone	
Father's Name	**Daytime phone**	
	Evening phone	
Email Address		

Street address	Apt	**City**	**Postal Code**
Referred by		**Date of last physical exam**	

PERSONAL HEALTH HISTORY

Childhood illness	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ DPT	☐ Hib
Briefly describe bad effects from vaccination (if any)		
Major complaints in order of importance		

Complaint	Since	Causes
1.		
2.		
3.		
4.		

Surgeries or Major Injuries

Year	Reason for Surgery *or* Type of Injury	Complications?

Are there any circumstances or conditions (illnesses) from which your child has never been totally well?

Year	Condition

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Are they currently under the care of a Physician?		☐ Yes	☐ No
Physician	Treated for	Date	
Have they had homeopathic treatment before?		☐ Yes	☐ No
Physician	Treated for	Date	

Check each of the following conditions they have had			
☐ Abscesses	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Chickenpox	☐ Cold sores	☐ Colitis	☐ Depression
☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Goiter
☐ Hay fever	☐ Heart disease	☐ Hepatitis	☐ Influenza
☐ Kidney disease	☐ Leukemia	☐ Malaria	☐ Parasites
☐ Pleurisy	☐ Pneumonia	☐ Scarlet fever	☐ Sexual abuse
☐ Skin disease	☐ Strep throat	☐ Sinusitis	☐ Tonsillitis
☐ Tuberculosis	☐ Warts	☐ Whooping cough	☐ Worms

List their prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the drug	Strength	Any adverse symptoms
Allergies to medications		
Name the drug	Reaction they had	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
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FAMILY HEALTH HISTORY

	AGE/AGE DECEASED	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
Paternal Aunts	☐ M ☐ F		**Grandmother** *Maternal*		
Paternal Uncles	☐ M ☐ F		**Grandfather** *Maternal*		
Maternal Aunts	☐ M ☐ F		**Grandmother** *Paternal*		
Maternal Uncles	☐ M ☐ F		**Grandfather** *Paternal*		

Check any of the following conditions present in your family

☐ Alcoholism	☐ Asthma	☐ Cancer	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Gonorrhea	☐ Gout
☐ Hay fever	☐ Heart disease	☐ Insanity	☐ Paralysis
☐ Pneumonia	☐ Skin disease	☐ Syphilis	☐ Tuberculosis
☐ Other (please describe)			

PREGNANCY AND DEVELOPMENT

Mother's age at childbirth:			
Select if any of the following were experienced during pregnancy			
☐ Bleeding	☐ Nausea	☐ Illness	☐ Physical / Emotional trauma
☐ Hypertension	☐ Diabetes	☐ Medications	☐ Alcohol
☐ Drugs	☐ Cigarette consumption	☐ Miscarriage(s)	☐ Other
Birth History			
Birth Weight	Full Term	Premature	Late
Length of Labour	Complications		
List the age your child began the following activities:			
Sitting	Crawling	Walking	Talking
Feeding			
Breast fed ☐ Yes ☐ No	Duration	Formula	☐ Milk ☐Soy ☐ Alternative
Are there any food intolerances?		Age they began solid food	

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MEDICAL/PROFESSIONAL WAIVER: PLEASE READ THE FOLLOWING CAREFULLY (under 19yrs of age require a parent or legal guardian's signature).

I the undersigned, understand that **Nicholas Mazzoli is a classically trained Homeopath and not a licensed medical doctor**. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Nicholas Mazzoli, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current fee schedule. I also acknowledge that cancellation of appointments with less than 24hrs notice may result in a charge of $100.00.

Patient's name — Signature (parent/guardian)

Witness — Date

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