Darling Street Health Centre
1/449 Darling Street
Balmain 2041
9555 8806

Natural Wisdom
220a Glenmore Rd
Paddington 2021
0400 551 622

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belinda@belindakirkpatrick.com.au

Name: _____ DOB: _____

Parent/guardian name/s: _____

Address: _____

Phone: _____ Email: _____

Name/s and age/s of siblings: _____

Height: _____ Weight: _____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reason for your appointment and other current health concerns:

1. _____
2. _____
3. _____

Recent pathology/tests/investigations/operations etc:

_____

_____

_____

Current medications (including dosage):

_____

_____

_____

Current supplements (dose and brand):

_____

_____

Please list any health concerns of family members including siblings, parents and grandparents:

_____

_____

_____

Please list any previous medical history:

_____

_____

_____

Please explain your child's general temperament:

_____

_____

Has your child taken any antibiotics? If yes, when and how many?

_____

_____

Did you experience any pregnancy complications?

_____

_____

☐ What was your child's birth weight? _____

☐ Was your child breastfed? Exclusively? _____How long? _____

☐ Was your child formula fed? Which formula? _____

Birth details:

☐ Vaginal delivery

☐ Caeserean section

☐ Forceps delivery

☐ Vacuum extraction

☐ Foetal distress

☐ Low birth weight

☐ Premature delivery

☐ Prolonged labour

Early development:

What age were solids introduced? _____

What age was your child toilet trained? _____

Were milestones achieved on time? _____

General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if your child has never experienced this symptom.

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux
- ☐ Colic
- ☐ Burping
- ☐ Nausea
- ☐ Daily bowel movements
- ☐ Irregular bowel movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fussy eating
- ☐ Stomach aches
- ☐ Poor appetite
- ☐ Difficulty gaining weight
- ☐ Recent weight gain
- ☐ Food intolerances. Please list: _____

_____

- ☐ Headaches
- ☐ Sleeping problems
- ☐ Night terrors
- ☐ Bed wetting
- ☐ Clingy
- ☐ Difficult to settle

_____

- ☐ Excessive whinging
- ☐ Anxiety
- ☐ Mood swings
- ☐ Poor concentration / focus
- ☐ Socially withdrawn
- ☐ Tantrums

_____

- ☐ Recurrent colds and flu
- ☐ Hayfever / sinusitis
- ☐ Asthma
- ☐ Slow wound healing
- ☐ Sneezing, coughing, wheezing
- ☐ Eczema or skin rashes
- ☐ Itchy eyes, ears, nose, throat, skin

_____

- ☐ Waxy ears
- ☐ Cradle cap
- ☐ Dry skin

Additional information: _____

_____

_____