EDUCATING
PROTECTING
HEALING

MIGHTY OAKS THERAPIES:
17774 Cypress Rose Hill Suite 320
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CLIENT QUESTIONNAIRE (0-17)

1. PERSONAL INFO

Name: _____

Date of Birth: _____ Initial Appointment Date: _____

2. MEDICAL HISTORY

What is the client's main concerns or complaints?

Has the client received formal homeopathic consultation prior to this visit? If so, list their name

☐ Yes _____ ☐ No

Which remedies did you responded well to?

Remedy	Frequency	Potency

Has the client been hospitalized? ☐ Yes ☐ No

Reason of hospitalization	Date

Detail any important medical diagnoses or conditions, including vaccination history and aprox dates :

Medical condition/diagnoses	Date

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2. MEDICAL HISTORY *(CONTINUED)*

What agents help or worsen this condition (ex: time of day, seasons, pressure, etc)?

List any allergies or food intolerances

Allergies	Food Intolerances	Reaction (ex: hives, throat closes,etc)

List medication, remedies, vitamins, supplements and frequency taken:

Name	Dose	Name	Dose

Has your child taken antibiotics?

☐No ☐ Yes, How often? _____

List frequently consumed foods (ex: drinks milk daily, only eats goldfish crackers, craves pickles, etc):

List any traumas the client has experienced or affected their life (ex: car accident, divorce)

Detail	Date

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3. FAMILY MEDICAL HISTORY

Describe the client's delivery type, mom's state during the pregnancy, info regarding birth: (any abnormal Apgar scores, extended hospital stays, complications, length of pregnancy- number of weeks, etc)

4. TREATMENTS

Professionals currently treating child:

- ☐ Pediatrician
- ☐ Neurologist
- ☐ Nutritionist/Registered Dietician
- ☐ ENT/Audiologist
- ☐ Physical Therapist
- ☐ Speech Therapist
- ☐ Occupational Therapist
- ☐ Developmental Optometrist
- ☐ ABA/Behavioral Therapists
- ☐ Special Educators

☐ Other Specialists (list below)

Vision Screening? ☐ Yes ☐ No

Identified deficits:

Hearing Screening? ☐ Yes ☐ No

Identified deficits:

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5. SYMPTOMS

Check any of the child's symptoms or traits below that were/are of concern:

- ☐ Anxiousness
- ☐ Fussy as baby
- ☐ Obstinate/Stubborn
- ☐ Rigid/Inflexible (mental)
- ☐ Extemely Overactive
- ☐ Resists touch input
- ☐ Aggressive
- ☐ Difficult to calm
- ☐ Leans on wall to stand
- ☐ W-Sits
- ☐ Sleeps a lot
- ☐ Difficulty falling asleep
- ☐ Wakes in night __am/pm
- ☐ Night Terrors
- ☐ Destroys Play Items Forcefully
- ☐ Teeth brushing aversion
- ☐ Hair brushing aversion
- ☐ Solitary play only
- ☐ Plays with younger kids
- ☐ Prefers adults in play
- ☐ Haircut avoidance
- ☐ Fearful Ascending stairs
- ☐ Fearful Descending stairs
- ☐ Toe walking
- ☐ Mouth-breather
- ☐ Easily fatigued
- ☐ Fearless/daredevil
- ☐ Climber
- ☐ Hyper-sensitive ears
- ☐ Incoordinated/clumsy
- ☐ Self-abusive/injurious behaviors
- ☐ Easily startled
- ☐ Withdraws from touch
- ☐ Resists new environments
- ☐ Shy/Withdrawn
- ☐ Hoards toys/objects
- ☐ Gazes at/Talks of spinning objects
- ☐ Spins items/self
- ☐ Obsessed w/ _____
- ☐ Hand flapping
- ☐ Facial tics/grimacing
- ☐ Low muscle tone
- ☐ Teeth grinding
- ☐ Lines up toys/objects
- ☐ Easily angered
- ☐ Abusive toward caregivers
- ☐ Demanding/impatient
- ☐ Props body for support/ head on hands
- ☐ Rigid body movements
- ☐ Delays with motor development
- ☐ No filter/tactless
- ☐ OCD/repetitive behaviors
- ☐ Socially awkward
- ☐ Leader/dominant alpha
- ☐ Pacing/ perimeter walking
- ☐ Lazy/ Doesn't expend energy
- ☐ Cautious
- ☐ Tuned out/ Zoned out
- ☐ Language delays
- ☐ Speech articulation delays

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5. SYMPTOMS *(CONTINUED)*

- ☐ Low self-esteem/ Confidence issues
- ☐ Difficulty with transitions
- ☐ Hyper-focused
- ☐ Threatens others verbally
- ☐ Everything's unfair
- ☐ Vaccine-injured
- ☐ Oppositional/Defiant
- ☐ Unpredictable
- ☐ Predictable/Rigid with routines
- ☐ Seizures/History of
- ☐ Ear infections/Tubes placed
- ☐ Pertussis/Whooping cough
- ☐ Measles or mumps
- ☐ Chicken pox/varicella
- ☐ Herpes complications
- ☐ Psoriasis
- ☐ Eczema
- ☐ Ringworm
- ☐ Skin picking
- ☐ Pulling out hair
- ☐ Not toilet-trained
- ☐ Extreme holding of urine/feces
- ☐ Eats/licks inedible objects/items
- ☐ Definite/ Consistent fears
- ☐ Cannot remain still
- ☐ Gut issues - Colic
- ☐ Gut issues - Worms/Parasites
- ☐ Gut issues - Diarrhea
- ☐ Gut issues - Constipation
- ☐ Gut issues - Nausea/vomiting
- ☐ Food aversions
- ☐ Food allergies
- ☐ Extremely limited diet
- ☐ Thirstless
- ☐ Overly thirsty

Describe specifics regarding the above concerns (ex: OCD- she must open every blind at night before going to bed; his low muscle tone makes him lean against wall for support while standing, she obsesses over spinning toilet water, watches ticking, ceiling fans, and overruns conversations about these subjects, etc) Your descriptive statements assist in finding a good remedy match.