CHILDREN'S CHECKLIST

Child's Name ________________________________ Age_______ Sex_______ Date ___/___/___
Parent's Name____
Address __________________________ City _________________ State _____ Zip __________
Home Phone __________________ Mobile Phone________________

Rate each of the following symptoms based on your child's current health profile.

POINT SCALE:

0 = *Never or almost never* has the symptom
1 = *Occasionally* has the symptom
2 = *Frequently* has the symptom

HEAD	____ Headaches ____ Difficulty falling asleep ____ Wakes up during the night	Total ____
EYES	____ Watery or itchy eyes ____ Dark circles under eyes ____ Bags under eyes ____ Swollen eyelids	Total ____
EARS	____ Reddening of ears ____ Itchy ears ____ Earaches / ear infections (circle which apply) ____ Drainage from ears ____ Hearing Loss ____ Frequent pulling on ears	Total ____
NOSE	____ Runny nose ____ Stuffy nose ____ Sneezing ____ "Allergic Salute" (rubs, itches, wipes nose frequently with hands)	Total ____
MOUTH/THROAT	____ Swollen or red lips ____ Gagging, frequent need to clear throat ____ Sore throat, hoarseness, loss of voice ____ Swollen or sore or discolored tongue ____ Swollen or sore gums, lips ____ Canker sores	Total ____
SKIN	____ Easy bruising ____ Hives ____ Rash ____ Dry or flaky skin ____ Flushing ____ Cold hands or feet ____ Eczema	Total ____
LUNGS	____ Coughing ____ Sneezing ____ Difficulty breathing ____ Wheezing	Total ____

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POINT SCALE:	0 = *Never or almost never* has the symptom 1 = *Occasionally* has the symptom 2 = *Frequently* has the symptom	
DIGESTIVE TRACT	____ Nausea ____ Vomiting ____ Diarrhea ____ Constipation ____ Bloated feeling ____ Belching ____ Passing gas (flatulence) ____ Heartburn ____ Tummy ache ____ Poor appetite ____ Refusal to eat	Total ____
JOINTS/MUSCLE	____ Coordination problems ____ Pain in muscles (e.g. leg aches) ____ Pain in joints (e.g. knee ache)	Total ____
ENERGY	____ Fatigue, sluggishness ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness ____ Sleeping problems	Total ____
MIND/ EMOTIONS	____ Inattentiveness or poor concentration ____ Mood swings ____ Anxiety, nervousness ____ Fear ____ Anger ____ Irritability ____ Aggressiveness (e.g. hitting, kicking, biting, etc.) ____ Crying or weepiness ____ Tantrums ____ Hyperactivity	Total ____
OTHER	____ Frequent urination ____ Itching of anus or genitals ____ Bed wetting ____ Wetting or soiling of clothes	Total ____
		GRAND TOTAL ______
Health concerns not listed on this form:		

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