



Martha DeMarco  
H O M E O P A T H Y  
*enhancing health naturally*

*Questionnaire for Children*

Please use extra sheets of paper if necessary

Child's Name: \_\_\_\_\_ Parents: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Parent Contact e-mail: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Parent's marital status: \_\_\_\_\_ Stepparents? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birthweight: \_\_\_\_\_

Height/Length: \_\_\_\_\_ Weight: \_\_\_\_\_ %tile (if known) \_\_\_\_\_

Referred by: \_\_\_\_\_

1. What is the child's chief complaint (CC)?  
\_\_\_\_\_  
\_\_\_\_\_
2. When did this problem begin? What happened in the child's life around that time?  
What do you think caused it? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. What aggravates the CC (certain types of foods or weather, movement, light, noise,  
heat/cold, being at the seashore, or anything else that you can think of)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. At what time of the day or night is the CC the worst? Specify an hour if you can.  
\_\_\_\_\_
5. What symptoms can you identify that accompany the CC?  
\_\_\_\_\_  
\_\_\_\_\_
6. What was your predominant emotional state when pregnant with this child?  
\_\_\_\_\_  
\_\_\_\_\_
7. During the pregnancy, did you suffer any particular shocks or traumas or losses?  
\_\_\_\_\_  
\_\_\_\_\_
8. Did you take any medication?  
\_\_\_\_\_  
\_\_\_\_\_

**DeMarco Homeopathy**

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50 Country Way A-101 Scituate, MA 02066

9. How did your food cravings and aversions change during pregnancy?

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10. Were there any particular complications at birth?

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11. At what age did the child reach these stages:

weaning \_\_\_\_\_ talking \_\_\_\_\_ toilet training \_\_\_\_\_

crawling \_\_\_\_\_ walking \_\_\_\_\_

12. How did the child react to these situations? Please try to think of mental and emotional reactions as well as any physical symptoms that may have developed.

Vaccinations \_\_\_\_\_ birth of younger sibling \_\_\_\_\_ starting daycare

regularly \_\_\_\_\_ first day at school \_\_\_\_\_ spending the night with a

friend \_\_\_\_\_ traveling with the family \_\_\_\_\_ going away to camp etc.

without the family \_\_\_\_\_

13. How many rounds of antibiotics has the child had, and for what?

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14. Any skin conditions treated with cortisone cream?

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15. Did the child suffer from a childhood disease with very severe symptoms? (measles, chickenpox, German measles, croup, mumps, etc.)?

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16. When ill or upset, does the child tend to cling to you or want to be left alone?

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17. What is the child's behavior in playing with other children? Does it make a difference if the other kids are older or younger?

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18. What feedback do you get from your child's teachers about behavior in class?

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19. What pets do you have, and what is your child's attitude towards them?

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20. a) What types of food does your child crave? Please be specific.

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b) What types of food does she/he refuse to eat? \_\_\_\_\_

c) What types of food does your child react badly to, whether physically (bloating, diarrhea, etc.) or behaviorally, and what are the reactions?

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21. Any fears that are unusual for a child of your child's age (of the dark, being alone, lightning, thunder, etc.) Are there nightmares?

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22. Is the child chilly? Is there excessive perspiration on the head and/or feet?

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23. Is the child very affectionate when not sick?

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24. Is the child unusually sympathetic (showing concern for the suffering of other children, animals, etc.)?

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25. Does the child like music? What kind? Like dancing? Do symptoms (like restlessness) improve with music?

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26. Is the child obstinate? How is this expressed?

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27. Is the child fastidious?

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28. Is the child sensitive to criticism and reprimand?

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29. Can you think of any unusual or distinctive things about your child—behavior, fears, fantasies, desires, attachments, preferences in clothing, etc.?

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30. Give a timeline for the child with all possible traumas, diseases, important events, deaths in the family. Describe the reaction of your child towards these events.

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31. Please list any medications, herbs, supplements, or homeopathic remedies your child is currently taking:

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32. Credit card information:

Card number: \_\_\_\_\_ Expiration: \_\_\_\_\_

Code: \_\_\_\_\_ Zip code of cc billing address: \_\_\_\_\_

Please return to [martha@demarcohomeopathy.com](mailto:martha@demarcohomeopathy.com)