KENNEALLY ACUPUNCTURE & HEALING Resource CENTER
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CHILD'S HEALTH HISTORY QUESTIONAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note in the "Comments" sections. Thank you.

Date:		**Referred By:**			
Your Child's Name:					
Address:			**City:**		
State:		**Zip:**		**Your Home #:**	
Your Work #:				**Your Cell #:**	
Height:		**Weight:**		**Sex:**	❑ M ❑ F
Date of Birth:		**Place of Birth:**			
Mother's Name:		**Father's Name:**			
Family Physician:					
Your child's main problems:					
When did this problem start?					
What treatments have you tried?					

Past Medical History:

Surgery(s):	
Trauma (accidents requiring significant medication):	
Any Problems With Pregnancy:	
Any Problems With Birth:	

Please list immunizations with dates and any reaction you noticed:

DPT:	1st:	2nd:	3rd:	Reaction:
APV	1st:	2nd:	3rd:	Reaction:
MMR	1st:	2nd:	3rd:	Reaction:
Other	1st:	2nd:	3rd:	Reaction:

What Medication is your child taking (orthodox or complimentary)?

Has she/he had many courses of antibiotics?	❑ Lots	❑ Medium	❑ Few	❑ None
Allergies (drugs, chemicals, foods):				
Does your child wake at night?		How many times?		
Would you say your child's appetite was:	❑ Good	❑ Medium	❑ Small	
Is she/he choosy over food?		Does she/he take dietary supplements?		

How much does your child have of the following each day:

Cow's Milk:	Cheese:	Cola/Soda:	Juice:
Oranges:	Bananas:	Sugar:	

DOES YOUR CHILD SUFFER FROM ANY OF THE FOLLOWING?

GENERAL

- ❑ Recurrent Infections
- ❑ Sweating
- ❑ Sweating on Head
- ❑ Sweating After Eating
- ❑ Strong Thirst
- ❑ Fatigue
- ❑ Sudden Energy Drops
- ❑ Underweight

HEAD, EYES, EARS, NOSE, THROAT

- ❑ Headaches
- ❑ Earache
- ❑ Discharge From Ear
- ❑ Vision Problems
- ❑ Squint
- ❑ Spectacles
- ❑ Sore Eyes
- ❑ Watering Eyes

- ❑ Nose Bleeds
- ❑ Nasal Discharge
- ❑ Blocked Nose
- ❑ Snoring
- ❑ Sore Throats
- ❑ Tonsillitis
- ❑ Glands

SKIN

- ❑ Rashes
- ❑ Itching
- ❑ Eczema
- ❑ Oozing
- ❑ Pimples

DIGESTION

- ❑ Colic
- ❑ Loose Stools
- ❑ Evil Smelling Stools
- ❑ Green Stools
- ❑ Constipation (Does Not Go Every Day)

- ❑ Painful to Pass Stools
- ❑ Gas
- ❑ Swollen Tummy
- ❑ Protruding Umbilicus
- ❑ Other Digestion Problems
- ❑ Teething Problems

RESPIRATORY

- ❑ Phlegm
- ❑ Recurrent Cough
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Asthma

GENITO-URINARY

- ❑ Pain on Urination
- ❑ Blood in Urine
- ❑ Leakage in Day
- ❑ Wets Bed
- ❑ Rashes

MUSCULOSKELETAL

- ❑ Wry Neck
- ❑ Aching Back
- ❑ Clicky Hips
- ❑ Overweight
- ❑ Hernia

NEUROLOGICAL

- ❑ Seizures
- ❑ Nerve Damage
- ❑ Paralysis

DEVELOPMENTAL

- ❑ Small for Age
- ❑ Large For Age
- ❑ Late Developer
- ❑ Retarded

BEHAVIOURAL

- ❑ Difficulty Concentrating
- ❑ Vacant
- ❑ Moody
- ❑ Aggressive
- ❑ Temper Tantrums
- ❑ Autism
- ❑ Other: _____

WHAT THERAPIES HAVE YOU TRIED?

❑ Acupuncture	❑ Homeopathy	❑ Herbology	❑ Naturopathy

ANYTHING ELSE?

COMMENTS:

BASIC NUTRITION QUESTIONANAIRE					
Patient's Name:				Date:	
Please give specific answers of individual foods, not food categories, unless asked for.					
1.	What are your favorite foods, in order of preference?				
a.		b.		c.	
2.	What foods do you eat the most of, in order of quantity?				
a.		b.		c.	
3.	What foods do you eat most frequently?				
a.		b.		c.	
4.	What foods do you eat at every meal?				
a.		b.		c.	
5.	What foods do you eat at least once a day?				
a.		b.		c.	
6.	What foods do you eat at least three times weekly?				
a.		b.		c.	
7.	What foods do you eat at least once weekly?				
a.		b.		c.	
Score each group of food according to how often you eat them: 0 = Never; 1 = Rarely; 2 – Occasionally; 3 = Frequently					
Total the score at the end of the section					

Non foods: beverages, etc	
Desserts, candies, pastries, etc.	
Products made from white flour	
Products containing sugar	
Products containing chemical additives	
Processed meats; luncheon meats, bacon, etc.	
Ordinary, treated, commercial meats	
Processed (pasteurized) milk and its products	
Commercially canned fruits and vegetables	
Commercially frozen fruits and vegetables	
Commercial nuts	
TOTAL	

KENNEALLY ACUPUNCTURE & HEALING LIGHT CENTER

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NAET Consent Form

I, _____ certify that Dr. Devi S. Nambudripad/Kathleen Kenneally, L.Ac. does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques)

I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, Chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my dependent) to continue all medications and other treatment modalities as they have prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my dependent) get a life threatening reaction from the allergen I (my dependent) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If I (my dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, metal irritability, violent behaviors', etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am treating with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing, and coming within 5 feet or more as it was instructed by my practitioner of the substance(s) that I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent), did not clear them completely, I (my dependent) may require repeating the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

I give permission to the pain clinic to use my (my ward's) case study in educating other similar patients or accumulating data for research purpose without disclosing my real name or address. I give permission to take photograph of my (my ward's) diseased body part (e.g. in case of skin problems, etc.) to use in research or patient education purpose without disclosing my real name or address.

I have read or have had read to me the above statements and have had opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

_____ _____

Signature Date

_____ _____

Signature Date