Functional and Integrative Medicine of McCall

REVIEW OF MEDICAL SYMPTOMS FOR CHILDREN

Name: ______________________________ Date: ____________ DOB: ____________

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

Point Scale:
0 – *Never* or *almost never* have the symptom
1 – *Occasionally* has symptom
2 – *Frequently* has 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 ear
________ 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 or frequent need to clear throat
________ Sore throat, hoarseness, or loss of voice
________ Swollen or discolored tongue
________ Swollen or sore gums or lips
________ Canker sores
Total ________

Skin
________ Easy bruising
________ Hives
________ Rash
________ Dry or flaky skin
________ Flushing
________ Cold hands or feet
________ Eczema
Total ________

Review of Medical Symptoms, continued…

Lungs	______________	Coughing	
	______________	Sneezing	
	______________	Difficulty breathing	
	______________	Wheezing	Total ______________
Digestive Tract	______________	Nausea	
	______________	Vomiting	
	______________	Diarrhea	
	______________	Constipation	
	______________	Bloated feeling	
	______________	Belching	
	______________	Passing gas (flatulence)	
	______________	Heartburn	
	______________	Tummy ache	
	______________	Poor appetite	
	______________	Refuse to eat	Total ______________
Joints/Muscles	______________	Coordination problems	
	______________	Pain in muscles (ex: leg ache)	
	______________	Pain in joints (ex: knee ache)	Total ______________
Energy/Activity	______________	Fatigue or sluggishness	
	______________	Apathy or lethargy	
	______________	Hyperactivity	
	______________	Restlessness	
	______________	Sleeping problems	Total ______________
Mind/Emotions	______________	Inattentiveness or poor concentration	
	______________	Mood swings	
	______________	Anxiety, nervousness	
	______________	Fear	
	______________	Anger	
	______________	Irritability	
	______________	Aggressiveness (ex: hitting, kicking, biting)	
	______________	Crying or weeping	
	______________	Tantrums	
	______________	Hyperactivity	Total ______________
Other	______________	Frequent urination	
	______________	Itching of anus or genitals	
	______________	Bed wetting	
	______________	Wetting or soiling of clothes	Total ______________

Grand Total ______________