NeuroTarget Chiropractic

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# Histadelia, Histapenia, Kryptopyrrolurea Pediatric Assessment Form

Name: _____ DOB: _____ Date: _____

**Section 1:**

1. Good tolerance of cold? Yes No
2. Poor tolerance of heat? Yes No
3. Unexplained nausea? Yes No
4. Poor pain tolerance? Yes No
5. Excessive salivation? Yes No
6. A tendency towards hyperactivity? Yes No
7. Frequent cold/flu symptoms? Yes No
8. Phobias? Yes No
9. Highly motivated and hard-driving personality? Yes No
10. Good creativity/imagination? Yes No
11. Joint pain? Yes No
12. Swelling/stiffness? Yes No
13. Excessive perspiration? Yes No
14. Warm skin? Yes No
15. Do you sneeze in bright sunlight? Yes No
16. Are you shy and oversensitive? Yes No
17. Can you make tears easily, and are never bothered by a lack of saliva or a dry mouth? Yes No
18. Do you hear a pulse in your head on the pillow at night ? Yes No
19. Do you have frequent muscle cramps ? Yes No
20. Do you have a high sensitivity to pain ? Yes No
21. Do you get headaches regularly Yes No
22. Does your mind go blank at times ? Yes No
23. Do you have seasonal allergies, such as hayfever? Yes No
24. Do you tend to be a light sleeper Yes No
25. Do you only need 5 to 7 hours of sleep each night ? Yes No
26. Do you burn up foods rapidly ? Yes No
27. Have you thought seriously about suicide ? Yes No
28. Can you tolerate high doses of medication or drugs ? Yes No
29. Do you have large ears and long fingers or toes (Is your second toe longer than your big toe)? Yes No
30. Are you addicted to drugs, alcohol, or sugar? Yes No
31. Are you a perfectionist or an obsessive, Type-A personality? Yes No
32. Are you impulsive? Yes No
33. Do boys predominate among your siblings? Yes No

**Section 2:**

1. Canker sores? Yes No
2. No headaches or allergies? Yes No
3. Ideas of grandeur? Yes No
4. Undue suspicion of people? Yes No
5. Racing thoughts? Yes No
6. The feeling that someone or something is controlling your mind? Yes No
7. Have you ever had visual hallucinations? Yes No
8. Have you ever heard voices inside your head? Yes No
9. Ringing in the ears? Yes No
10. High anxiety? Yes No
11. Food sensitivities? Yes No
12. Good pain tolerance? Yes No
13. Few or no colds? Yes No
14. Is your mouth usually dry? Yes No
15. Are your eyes usually dry? Yes No
16. Do you have bouts of despair or bouts of crying? Yes No
17. Unusual sensitivity to chemicals, perfumes, gasoline, plastics, *etc*.? Yes No
18. Severe PMS? Yes No
19. Do you have tension headaches? Yes No
20. Do you have heavy growth of body hair? Yes No
21. Do you tend to carry any excess fat in your lower extremities rather than evenly distributed around your body (pear shaped figure)? Yes No
22. Do you have a lot of dental fillings? Yes No
23. Do you have a head full of grand plans but are easily frustrated? Yes No
24. Do you ever feel paranoid Yes No
25. Do you get few or no colds? Yes No
26. Do you have low tolerance for medications or drugs? Yes No
27. Do you tire easily? Yes No
28. Do you need at least 8 hours of sleep or are you a slow riser in the morning? Yes No
29. Do you experience frequent Irritability? Yes No

Name:_____ DOB:_____

## Section 3:

1. When you were young, did you sunburn easily? Yes No
2. Do you have pale or fair skin? Yes No
3. Do you have a reduced amount of head hair, eyebrows, eyelashes, or do you have prematurely grey hair? Yes No
4. Do you have poor dream recall or Nightmares? Yes No
5. Are you becoming more of a "loaner" as you age? Yes No
6. Do you avoid outside stress because it upsets your emotional balance? Yes No
7. Have you been anxious, fearful or felt a lot of inner tension since childhood but mostly hide these inner feelings from others? Yes No
8. Is it hard to clearly recall past events and people in your life? Yes No
9. Do you have bouts of depression and/or exhaustion? Yes No
10. Do you have cluster headaches Yes No
11. Are your eyes sensitive to sunlight Yes No
12. Do you belong to an all-girl family, or have look-alike sisters? Yes No
13. Do you get frequent colds and/or infections, or unexplained chills or fevers? Yes No
14. Do you dislike eating protein? Yes No
15. Have you ever been a vegetarian? Yes No
16. Did you reach puberty later than normal? Yes No
17. Are there white spots/flecks on your fingernails, or do you have opaquely white or paper-thin nails? Yes No
18. Are you prone to acne, eczema or psoriasis? Yes No
19. Do you prefer the company of one or two close friends rather than a gathering of friends? Yes No
20. Do you have stretch marks on your skin? Yes No
21. Have you noticed a sweet smell (fruity odor) to your breath or sweat when ill or stressed? Yes No
22. Do you have, or did you have before braces, crowded upper front teeth? Yes No
23. Do you prefer to not eat breakfast, or even experience light nausea in the morning? Yes No
24. Does your face sometimes look swollen while under a lot of stress? Yes No
25. Do you have a poor appetite, or a poor sense of smell or taste? Yes No
26. Do you have any upper abdominal, splenic pain? Yes No
27. As a child did you ever get a "stitch" in your side as you ran? Yes No
28. Do you tend to focus internally (on yourself) rather than on the external world? Yes No
29. Do you frequently experience fatigue? Yes No
30. Do you feel uncomfortable with Strangers? Yes No
31. Do your knees ever crack or ache? Yes No
32. Do you overreact to tranquilizers, barbiturates, alcohol or other drugs (does a little produce a powerful response)? Yes No
33. Does it bother you to be seated in the middle of a room? Yes No
34. Are you anemic? Yes No
35. Do you have cold hands/feet? Yes No
36. Are you easily upset (internally) by criticism? Yes No
37. Do you have a tendency towards morning constipation? Yes No
38. Do you have a tingling sensation or muscle spasms in your legs or arms? Yes No
39. Do changes in your routine (traveling, new situations) provoke stress? Yes No
40. Do you tend to become dependent on one person whom you build your life around? Yes No