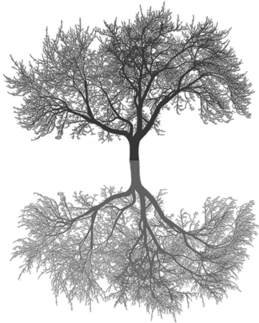

HOMEOPATHIC HEALING

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PEDIATRIC INTAKE FORM (up to 14 yrs)

Scheduled Appointment: ______________________________

Patient's Name: ____________________ Patient's Age: ____________

Mother's Name: ____________________ Father's Name: ____________

Address: ______________________________

Home Phone: ____________________ Work Phone: ____________

Cell Phone: ____________________ Email: ____________

How did you hear about me? ______________________________

Present MD and Phone # ______________________________

Homeopathy is a system of medicine that stimulates the body to heal itself. This is accomplished by addressing the imbalances of the body, which lead the patient to their diseased state. To a classical homeopath, the symptoms, which can be physical, emotional or mental, are an expression of the body's attempt to cure and as such can be used to cure homeopathically, curing "like with like". After successful treatment, the patient will find they are healthier and more vital as a whole, because the symptoms were honoured by the body's own attempt to cure, and were not suppressed.

Determining the proper remedy involves investigating and evaluating all of the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time in consultation most effective, I request that you complete the following information form as fully and as accurately as possible. If you have questions, feel free to contact me. Please note that all information you provide is kept in the strictest confidence according to the laws of homeopath/patient confidentiality.
I welcome you to your journey with homeopathic medicine!

Major Complaints In Order of Importance:

Complaint	Since	Cause

What Medications Is Your Child Currently Taking?

Medication and Condition	Since (age)	Adverse Effects

Circle Any Of The Conditions Your Child Has Had:

Abscesses	Cold Sores	Measles	Rubella	Thrush
Anemia	Colic	Mood Swings	Scarlet Fever	Tuberculosis
Anxiety	Depression	Mumps	Skin Disease	Typhoid Fever
Arthritis	Diabetes	Mononucleosis	Strep Throat	Warts
Asthma	Eating Disorder	Parasites	Sinusitis	Whooping Cough
Cancer	Eczema	Pneumonia	Sun Stroke	Worms
Chicken Pox	Frequent Colds	Rheumatic Fever	Tonsillitis	

Any Other Medical Conditions? ______________________

Are There Any Conditions After Which Your Child Has Never Felt Totally Well Since?

Which Ones?

____

____

Any Serious Shock, Grief, Disappointment, Fright, Mental Upset, Depression?

____

____

____

____

Any Major Operations/Injuries?

Operation/Injury	When	Complications

Has Your Child Been Treated With Homeopathy Before?

Practitioner	When (age)	For What Condition? Remedy Given

Vaccination History:

Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Meningitis	Yes	No
Hep B	Yes	No
Tetanus	Yes	No
Flu Shot	Yes	No

Any Adverse Effects From Any Of These Vaccinations?

Health History of Relatives

Indicate Below, Which Of The Following Ailments, Or Any Other Major Ailments, Have Affected Your Relatives:

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

Relative	Age If Alive	Age At Death	Ailments
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

Previous Pregnancies By Natural Mother, Miscarriages, or Complications:

Mother's Age At Child's Birth:

Mother's Health During Pregnancy.
List Any Bleeding, Nausea, Illness, Physical or Emotional Trauma, Hypertension, Diabetes, Medications, Alcohol, Drugs, Tobacco, etc.

Your Child's Birth

Full Term ______ Premature ______ Late ______ Weight At Birth ______

Length Of Labour: ______ Complications: ______

Growth And Development

Age Your Child Began:

Teething: ______ Walking: ______

Sitting: ______ Speaking: ______

Began Solid Foods: ______

Eating Indigestibles Like Chalk, Earth, Pencils, etc. ______

Any Other Issues With Your Child's Growth And Development?

What Is Your Child Especially Like? Please Describe.

Is There Any Other Information That You Think I Need To Know About Your Child?