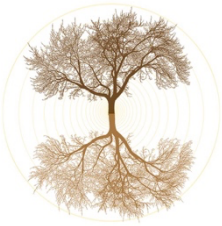


HOMEOPATHIC HEALING

SARAH TRASK, DSHomMed Hons, RHom, BKin

Pediatric Intake Form

Scheduled Appointment:_____

Patient's Full Name:_____

Patient's Age:_____ Birthdate:_____

If patient is under 18 years old Parents/Guardians Name/s:_____
_____

Mailing Address:_____
_____

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!

4 Little Rd, Suite #6, Wolfville, NS 902-542-2317
www.sarahtrask.com info@sarahtrask.com

List of major complaints in order of importance:

Complaint	Since	Cause

List of medications and dosages your child is currently taking:

Medications/Dosage	Since	Adverse effects

What other treatments or regimes is your child currently following?

Treatment/Regime	Since	Results

Please underline any of the following conditions your child has had once, and if more than once please circle. Abscess -ADD/ADHD -Allergies -Anemia -Anxiety -Arthritis -Asthma -Cancer - Celiac -Chicken Pox -Cold Sores -Constipation -Convulsions -Croup -Depression -Diabetes -Ear Infections -Eating Disorder -Eczema -Epilepsy -Frequent colds -Heart Disease -Irritable Bowel Disease -Influenza -Kidney Disease -Leukemia -Lupus -Lyme -Measles -Mono -Mumps -Parasites -Pneumonia -Psoriasis -PTSD -Rheumatic Fever -Rheumatoid Arthritis -Rubella -Scarlett Fever -Seizures -Sexual Abuse -Skin Disease -Sinusitis -Strep Throat -Sunstroke -Tics -Thrush -Tonsilitis -Tourettes -Tuberculosis -Tumor -Typhoid Fever -Warts -Whooping Cough -Worms

Any other major conditions?_____

Surgeries/Operations (please list)

Operation	When	Complications?

Accidents/Injuries (please list)

Injury	When	Long Term Effect

Age of first menses/period/puberty:_____ Complications:_____

Childhood Vaccines: Yes/No Adverse effects:_____

Covid MRNA: Yes/No Adverse effects:_____

Unexplainable weight loss/gain lately? Yes/No If Yes, Please explain? _____

Are they any major conditions after which your child has felt never well since? _____

_____

Any Serious Shock, Grief, Disappointment, Fright, Mental Upset, Depression? Please explain:

_____

_____

Has your child been treated with Homeopathy before? YES/NO If yes, which remedies and for what conditions? _____

_____

Do your relatives have any of the following conditions? Please circle:
-Alcoholism -Asthma -Autoimmune Disease -Diabetes -Gout -Insanity -Skin Disease -Cancer -Epilepsy
Congenital Disorder -Arthritis -Depression -Heart Disease -Tuberculosis

Relative	Age if Alive	Age at Death	Ailments (Please list if more than one)
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunt/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Is your child currently under the care of another physician/practitioner? Please list who and for what conditions:_____

_____

_____

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. Premature____ Full Term____ Late____ Weight at birth_____

Complications of pregnancy/labour/delivery:

_____
_____
_____

Growth and Development
Age your child began:
Teething:_____ Sitting_____ Walking:_____ Speaking:_____

Eating indigestibles like chalk, dirt, earth, etc: YES/NO

Please describe your child's personality:_____
_____
_____

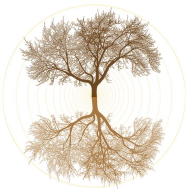
Please describe your child's general thermal profile (chilly, hot, perspiration, etc)_____
_____
_____

What is your main goal for seeking Homeopathic Treatment?_____

Is there anything in your child's environment you feel is holding your child back from being at optimal health?
_____

If there is anything else that is unique to your child that you would like to share, please do so here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



HOMEOPATHIC HEALING BY SARAH TRASK, DSHomMed Hons

WAIVER OF LIABILITY FOR HOMEOPATHIC TREATMENT

I, _____, the undersigned, understand that Sarah Trask is not a medical doctor, but is a Classical Homeopath. As such, I acknowledge that it is my right and responsibility at any time through my treatment in Homeopathic Healing by Sarah Trask, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate homeopathic treatment at any time. As such, I agree that should Sarah Trask need to terminate treatment at any time, it is her right to do so. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose another method of treatment, homeopathy, which addresses my health in its entirety. This includes sharing any pertinent information and co-operating with Sarah Trask in case taking, as well as tracking symptoms as needed through treatment. As homeopathy is not covered by the existing government medical plan, I agree to pay all fees presented in the current rate schedule at the time of provided service. I acknowledge that all personal information will be kept confidential and I have read, understood and agree to the terms and conditions for private homeopathic treatment.

Fee Schedule:
Initial $340.00 + HST (includes remedy)
Follow-up Consultation $100 + HST
Acute Consultation (by phone in or in person) – $60- $80 + HST depending on time needed
PRT (Pattern Reflection Technique $70-150 depending on time needed (please inquire)

*PLEASE HONOR OUR SCENT FREE OFFICES BY REFRAINING FROM WEARING ANY SCENTS OR FRAGRANCES

*Some extended health care plans cover homeopathy. Please check with your health care group provider.

PLEASE NOTE: Payment and Cancellation Policy

- All fees are payable at the end of each consultation (Debit, Visa, or MasterCard)
- If you are unable to keep an appointment, please provide 24 hours-notice to avoid being invoiced

The fee for ALL missed appointments is the full amount of the appointment.
Please sign below to acknowledge you are in agreement with the waiver, cancellation policy, fee schedule, Terms and Conditions, and payment policy.

Patient's Signature_____

Date_____

(If under 18 yrs old, a parent or guardian must sign on your behalf)

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www.sarahtrask.com info@sarahtrask.com