HOMEO WELLNESS CLINIC

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Infant /Child Homeopathic Intake Form

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge.
Even the smallest details are important.

Name of Parent(s)/Guardian(s)

_____

Address: _____
City: _____Province: _____Postal code: _____
Tel (H): _____ (W): _____
(c): _____ Email: _____
Marital status of parents: _____
Child's Name: _____
Child's Date of Birth: _____
Age: _____ Sex: _____ Current Weight: _____
Current Height: _____
Number of siblings and their ages:

_____

_____

_____

_____

_____

Parent's Occupation: _____

_____

Emergency contact person and ph#:

_____

How did you hear about Homeo Wellness clinic?

_____

Name, address and phone number of your family physician:

Has your child been treated by a Homeopath before? If YES, please list his or her name: _____

LIST YOUR CHILD'S MAIN HEALTH CONCERNS AND WHEN THEY BEGAN:

1.

2.

3. _____

Can you trace the origin of any of these concerns to a particular event, accident, illness or mental upset?

What makes your child feel better?

What makes him/her feel worse?

List and date any treatments, medications, herbs or remedies used now or in the past:

_____
_____
_____

BIRTH HISTORY:

Child's weight at birth: _____
Was delivery normal or difficult? _____
Explain if difficult:

_____
_____
_____

No. hours in labour: _____ premature delivery: _____
Caesarean: _____ Epidural: _____
Other _____

MOTHER'S PREGNANCY HISTORY:

Difficulties becoming pregnant: _____
Weight gained: _____

Did you experience any of the following?

Nausea: _____ Vomiting: _____ Anemia: _____

Toxemia: _____Blood pressure changes: _____

Diabetes: _____Eclampsia:_____ shocks/trauma:

_____

If other complications: (please specify)

_____
_____
_____

Emotional upsets (specify):

_____
_____

Overall mental state:

_____
_____

Post partum depression or other complications after delivery:
_____
_____
_____

INDICATE YOUR USE OF THE FOLLOWING DURING PREGNANCY OR BREAST FEEDING:

Cigarettes_____ Alcohol _____Recreational drugs_____

X-rays: _____anti-nausea medications: _____

Antibiotics.....Green tea.....Coffee.....Black tea.....Antibiotics...

.....Sedatives.....Anti-depressants.....Anti-inflammatory

Painkillers.....Steroids.....Laxatives.....Other.....

DEVELOPMENTAL HISTORY:

Did you breast feed and for how long: _____

Milk intolerance: _____

Latching Difficulty: _____

Other feeding problems (formula/solids): _____

Co-ordination problems: _____

Growth problems: _____

Crawling/Standing/Walking Difficulties: _____

Speech / Language Difficulties: _____

Visual / Hearing Difficulties: _____

Dentition Problems: _____

Other developmental difficulties: _____

Vaccination Reactions (fever/rash/cold/sweats/etc): _____
_____

CHILDHOOD DISEASES /INJURIES:
_____
_____

Frequent colds…… Influenza…… Measles…….Mumps……Croup or whooping cough……. Chickenpox…… Diaper rashes……burns injuries……others (Specify)…….
……

Other diseases/accidents/injuries: ……

Medications administered for any of the above.……

SURGERIES:
1……when……
2……when……
Other……

Medications administered for above _____
_____

Was the recovery time normal or excessively long
_____

CIRCLE ANY OF THE FOLLOWING PAST OR CURRENT CONDITIONS

Jaundice lack of energy hyperactivity sleeping problems

Learning problems Nervousness constipation/diarrhea

Behaviour problems convulsions heart problems digestive upsets

Skin rashes bedwetting Allergies eczema/psoriasis

Asthma ear infections nosebleeds bleeding gums

Foul odours (stool/breath/sweat/urine) loss of appetite

Excessive appetite eating disorder Anxiety

Depression/sadness Worms frequent or recurrent illness

Other (Specify) _____

Medications administered for above
_____
_____

HAVE YOU OBSERVED ANY OF THE FOLLOWING IN YOUR CHILD?

Fears/phobias (specify)

_____

_____

Lack of confidence _____
Excess timidity/shyness_____
Makes friends easily _____
Likes to be with friends _____
Prefers to be alone _____
Prefers one parent _____
Aversion to be carried / rocked _____
Better when rocked or carried _____
Rejects attention when sick _____
Startles when being put down or going down stairs _____
Hard to please? _____
Gets angry easily _____
Startled /Noise sensitive _____
Tantrums _____
Biting / kicking /head banging etc _____
Aggression /Violence /cruelty /Passivity _____
Affectionate / Averse to being held _____
Laziness _____
Resistance to change _____
Motion sickness _____
Seems to learn slowly _____
Easily distracted_____
Difficult concentration _____
Sleeps long hours, hard to wake in the morning _____
Needs little sleep _____
Difficulty in settling for sleep _____
Kicks off covers, Prefers cold room _____
Excessive crying _____
Easily weepy _____
Aversion to bathing _____
Prefers fresh air _____
Prefers to be wrapped/covered _____
Nightmares (specify)

_____

Eyes sensitive to light _____
Poor eye contact _____
Decreased interest in environment _____
Grinds teeth _____
Nail biting _____
Excess scratching and picking of skin, ears, nose and /or anus _____
Inclination to touching genitals _____
Coldness in limbs or torso _____

Food cravings _____

Food intolerances, allergies or aversions (specify)

_____

_____

Other observations: _____

_____

Favourite toys, games, hobbies, activities, sports

_____

_____

Academic history and aptitudes:

_____

_____

Family History

RELATIONSHIP	AGE	IF DECEASED, AGE AT DEATH	CAUSE OF DEATH	DISEASES
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister(s)				
Brother(s)				
Aunt(s)				
Uncle(s)				
Children				

Family Physician (Name and number):

_____

PATIENT CONSENT:

I, parent/ guardian named _____, of the following address

_____

_____

Consent to treatment of my son or daughter _____ by homeopath, Shagufta Karimi at Homeo wellness clinic. I confirm that there has been no suggestion made to me by anyone or control to prevent me from seeking or following allopathic treatment. The decision to seek homeopathic treatment is solely my decision and I understand that I may still seek the treatment of an allopathic doctor or any other health practitioner as needed. All information disclosed is confidential and remains within the premises of Homeo wellness clinic.

Dated and signed this _____ (day) of _____ (month) _____ (year)

Signature_____

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