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**Homeopathic Intake Form for an Infant and/or Young Child**

*Please complete the intake form to the best of your ability.*

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| **Overview of Personal and Family Information** |
| Name of Infant/Child:  Date of Birth: Weight at Birth:  Current Weight: Current Height:  Age: Sex:  Address:  City: Province: Postal Code:  Daytime Phone:  Email:  Emergency Contact: Phone number: |
| Name of Parent/Guardian 1: Occupation:  Relationship to infant/child:  Name of Parent/Guardian 2: Occupation:  Relationship to infant/child:  Name of Parent/Guardian 3: Occupation:  Relationship to infant/child:  Marital status of parents:  Number of siblings: Infant/Child’s Birth Order:  Pets or animals living in the home: |
| Has your child or anyone in the family used homeopathic medicine? Please provide the name, address and phone number of your homeopath: |
| Do you have a medical physician? Please provide the name, address and phone number of your family physician:  **Health Concerns** |
| Child/Infant’s main Concern[s]: |
| What do you think caused this problem? |
| When do you observe this? What do you observe? |
| What helps make it better?  Does anything make it worse? |

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| **Mother/Infant/Child’s State during Pregnancy, Labour and Breast Feeding** |
| Please mention any changes during pregnancy in food and dreams: |
| Please describe the labour and the process: |
| Breast Feeding:  Is/Was the infant/child being breastfed?  How long?  Were there issues? |
| Please **list all and any** medications taken by the mother during pregnancy:  Medication 1 reason for taking it…  Medication 2 reason for taking it…  Medication 3 reason for taking it…  Medication 4 reason for taking it…  Medication 5 reason for taking it… |
| Any use of addictive substances during pregnancy, birth and/or breastfeeding  What is/was your experience of breastfeeding? |
| Did you have any injections during pregnancy, labour and breastfeeding? |
| Has your child had any substances injected into them?  Please list them as substance/date  Substance 1 Date: |

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| --- | --- | --- | --- |
| **Has your child suffered any of the following illnesses/difficulties/injuries** | YES  **Y** | NO  **N** | **What medications and/or interventions were/are used?** |
| Feeding problems |  |  |  |
| Growth problems |  |  |  |
| Dentition problems |  |  |  |
| Speech problems |  |  |  |
| Hearing problems |  |  |  |
| Visual problems |  |  |  |
| Co-ordination problems |  |  |  |
| Developmental problems |  |  |  |
| Birth abnormalities |  |  |  |
| Constipation |  |  |  |
| Diarrhea |  |  |  |
| Croup or whooping cough |  |  |  |
| Chickenpox |  |  |  |
| Skin rashes |  |  |  |
| Eating disorders |  |  |  |
| Worms |  |  |  |
| Ear infections |  |  |  |
| Behavioural problems |  |  |  |
| Learning problems |  |  |  |
| Eczema or psoriasis |  |  |  |
| Sleep disorders |  |  |  |
| Digestive problems |  |  |  |
| Allergies |  |  |  |
| Asthma |  |  |  |
| Bedwetting |  |  |  |
| Heart problems |  |  |  |
| Nose bleeding |  |  |  |
| Anxiety or nervousness |  |  |  |
| Hyperactivity |  |  |  |
| Jaundice as a newborn |  |  |  |
| Jaundice later in life |  |  |  |
| Autoimmune disease |  |  |  |
| Birth defect or birth disease |  |  |  |
| Diabetes |  |  |  |
| Other |  |  |  |
| Other |  |  |  |
| Other |  |  |  |

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| --- | --- |
| **Observation: What do you observe regarding the following…** | **Please elaborate…tell me more**  [put N/A if not applicable] |
| Level of affection |  |
| Ways of sleeping |  |
| Ways of being wrapped |  |
| Ways of eating |  |
| Ways of responding |  |
| Levels of startling |  |
| Tantrums |  |
| Crying/weeping |  |
| Anger |  |
| Being carried |  |
| Doesn’t want to be touched |  |
| Response to water |  |
| Response to being put down |  |
| Response to strangers |  |
| Response to voice |  |
| Response to being pleased |  |
| Response to change |  |
| Response to attention |  |
| Response to familiar people |  |
| Response to people |  |
| Response to animals |  |
| Response to light |  |
| Response to dark |  |
| Nail biting |  |
| Grinding teeth |  |
| Stomach gas |  |
| Excessive scratching or pulling of skin |  |
| Picking at body parts |  |
| Eating unusual substances that are not food |  |
| Scratches anus |  |
| Food cravings |  |
| Food intolerances |  |
| Coldness on parts of body |  |
| Temperatures – which pars are red |  |
| Inclination to masturbate/touch genitals |  |
| Favourite objects |  |
| Obsessive behaviours |  |
| Others |  |

**Extended Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Relationship | Age | Alive or deceased | Cause of death | Diseases |
| Mother |  |  |  |  |
| Maternal Grandmother |  |  |  |  |
| Maternal Grandfather |  |  |  |  |
| Father |  |  |  |  |
| Paternal Grandmother |  |  |  |  |
| Paternal Grandfather |  |  |  |  |
| Sisters |  |  |  |  |
| Brothers |  |  |  |  |
| Aunts |  |  |  |  |
| Uncles |  |  |  |  |
| Other |  |  |  |  |

Thanking you in advance. Wishing you good health and happiness always!