

Homeopathy Centre

Dr.Raisa Weisspapir HD, DHMS, MD (Europe)
www.homeopathytoronto.com

3910 Bathurst Street, Suite 207, Toronto, Ontario, M3H 5Z3
Tel: (416) 227-1485

Childs Name: _____ Age: _____ Date of Birth: D/M/Y _____
 Address: _____
 City: _____ Postal Code: _____ Email _____
 Home Phone: _____ Mother's name: _____ Father's name: _____
 Family Physician: _____ Phone: _____
 Referred by: _____

CHILD'S MAIN HEALTH CONCERNS:

MEDICAL HISTORY:

Ht: _____ Wt: _____

Vaccinations:

Tetanus: _____ Polio: _____ Pertussis: _____
 Diphtheria: _____ Measles: _____ Mumps: _____
 Chickenpox: _____ Other: _____

CONDITION	PAST	PRES.
Jaundice		
Lack of Energy		
Hyperactivity		
Difficult to please		
Cries a lot		
Bedwetting		
Convulsions		
Ear infections		
Eczema / Rashes		
Constipation		
Vision problems		
Speech problems		

CONDITION	PAST	PRES.
Colic		
Sleeping Difficulty		
Learning Disability		
"Problem Child"		
Nervous Child		
Tantrums		
Breathing problems		
Heart murmur		
Digestive upsets		
Diarrhea		
Teeth problems		

CHILDHOOD DISEASES	YES	NO	CHILDHOOD DISEASES	YES	NO
Frequent colds			Measles		
German measles			Chicken pox		
Whooping cough			Diphtheria		

Injuries / Burns: _____ **Accidents:** _____
Surgery: _____ **Hospitalization:** _____

BIRTH HISTORY:

Weight at birth: _____ Rh Blood Problem? Yes No
Birth complications - during or after delivery- Please explain: _____

Delivery: Normal: _____ Premature: _____ Caesarean: _____
Forceps: _____ At Home: _____ Hospital: _____
Difficult: _____ No. Hours in labour: _____ Drug aided: _____
Feeding: Breast? Yes No How many months? _____
Type of formula: _____
Solid foods started at: _____ months.
Foods introduced first: _____

Mothers Pregnancy History:

Difficulties in becoming pregnant? _____
Was the pregnancy stressful? _____

Did you have any of the following?

Nausea _____ Vomiting _____ Anaemia _____
Shocks/ Trauma _____ Hospitalization _____ Extreme fatigue _____

Were any of the following used during pregnancy?

Cigarettes _____ Alcohol _____ Recreational drugs _____
X-rays _____ Ultrasound _____ Sedatives _____
Sleeping pills _____ Antibiotics _____ Iron supplements _____

Were you on a special diet? _____ Why? _____
How many lbs/kg did you gain? _____

If you child is between the ages 12 and 16 please have him/her complete the following.

(Answer with: Never; Sometimes; Often)

Do you.....

Have many fears? _____ Lack of confidence? _____
Feel you are different? _____ Prefer to be alone? _____
Prefer to be with friends? _____ Prefer to be with family? _____
Get angry easily? _____ Have sleeping problems? _____
Bite your nails? _____ Grind your teeth? _____
Ever wet the bed? _____ Feel nervous? _____
Feel unhappy? _____ Feel hyperactive? _____
Sleep long hours? _____ Feel lazy? _____
Feel irritable? _____ Think you learn slowly? _____
Are you eyes sensitive to light? _____
Have difficulty concentrating on schoolwork? _____
How often do you miss school because of illness? _____
Do you get along with your family? _____
On a scale of 1-10 (10=very happy), How happy are you with your life? _____
If you could change something in your life, what would it be? _____

What do you worry about? _____

What are your health concerns? _____

Thank you!

