

# Homeopathy Centre

Homeopath 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!**

