Homeopathy Centre

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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!