Homeopathy and Wellness Centre of Raisa Weisspapir

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Childs Name: _____
Date of Birth: _____ Age: _____
Address: _____
City: _____ Postal Code: _____
Home Tel: _____ Email: _____
Mother's Name: _____Father's Name: _____
Family Physician: _____ Phone: _____
Referred by: _____

CHILD'S MAIN HEALTH CONCERNS:

_____
_____
_____

MEDICAL HISTORY: Ht: _____ Wt: _____

Vaccinations (check all that apply):

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

CONDITION	PAST	PRES.	CONDITION	PAST	PRES.
Jaundice			Colic		
Lack of Energy			Sleeping Difficulty		
Hyperactivity			Learning Disability		
Difficult to please			"Problem Child"		
Cries a lot			Nervous Child		
Bedwetting			Tantrums		
Convulsions			Breathing problems		
Ear infections			Heart murmur		
Eczema / Rashes			Digestive upsets		
Constipation			Diarrhea		
Vision problems			Teeth problems		
Speech 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):

_____
_____
_____

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? _____

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

(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!