HOMEOPATHIC TREATMENT

CHILDREN'S INTAKE FORM

Thank you for supplying the information necessary for assessing your child's state of health. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

NAME:_____AGE:_____ M/F HEIGHT_____WEIGHT_____

ADDRESS:_____

POSTAL CODE:_____PHONE:WORK_____HOME_____DATE_____

FAMILY PHYSICIAN:_____PHONE:_____

MOTHER AND FATHER'S NAMES_____

EMAIL: HOME _____

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WHAT ARE YOUR CHILD'S MAIN HEALTH CONCERNS.

1._____
2. _____

MEDICAL HISTORY:

Vaccinations:_____
Any side effects:_____
Any skin conditions after_____
Medications in use at present_____

PLEASE CIRCLE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

jaundice	lack of energy	colic
hyperactivity	sleeping problems	learning problems
nervousness	tantrums	constipation/diarrhea
convulsions	heart problems	digestive upsets
skin rashes	vision problems	speech problems
eczema/psoriasis	asthma	behaviour problems
ear infections	allergies	bedwetting
teething problems	dentition problems	frequent or recurrent illnesses

OTHER: _____

CHILDHOOD DISEASES:

Frequent colds..... Ear infections..... Measles.....Mumps.....
Croup or whooping cough..... Chickenpox..... Diaper rashes.....
Injuries/burns.....Explain:.....
Other.....

OPERATIONS

1.....when.....
2.....when.....

Other.....

BIRTH HISTORY

Child's weight at birth..... Rh blood problem.....yes, no
Birth complications.....
Delivery was normal.....yes, no
Difficult delivery.....yes, no, explain.....
No. hours in labour.....premature delivery.....yes, no
Caesarean.....yes, no epidural.....yes,no

Other.....

MOTHER'S PREGNANCY HISTORY

Number. of siblings and ages.....
Other pregnancies.....miscarriages.....
Difficulties becoming
pregnant.....
Was the pregnancy
stressful.....
Did you breast feed and for how
long.....
Problems with
feeding.....
Milk intolerance in the
baby.....

Did you have the following:

Nausea....., Vomiting....., Anemia.....,
Shocks/trauma.....
Emotional upsets.....Please
explain.....
Toxemia.....
Weight gained.....
Other.....

DID YOU USE THE FOLLOWING DURING YOUR PREGNANCY:

Cigarettes....., Alcohol....., Recreational drugs....., X-rays.....
Anti-nausea medications.....
Antibiotics.....Sedatives.....Other.....

NOTE IF YOU HAVE OBSERVED ANY OF THE FOLLOWING IN YOUR CHILD.

Fears.....Nightmares.....
Lack of confidence....., Excess timidity/shyness.....Preference to be alone.....Prefers to be with family.....Gets angry easily.....
Tantrums.....Biting, kicking, head-banging etc.....
Grinds teeth.....Seems nervous.....Hyperactive.....Lazy.....Seems to learn slowly.....Sleeps long hours, hard to wake in the morning.....
Cries a lot.....Eyes sensitive to light.....
Vision problems.....
Missing school because of illness or other.....
Co-ordination problems.....
Growth problems.....
Excess scratching and picking of nose and anus.....

OTHER PROBLEMS NOT MENTIONED.....