

# GETTING OVER IT *Naturally*

## Children's Initial Consultation Form

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Homeopathy is an individualized process of prescribing a remedy. The remedy prescribed is suited to you and only you. In order to help find the best suited remedy I need you to complete this form. Please fill it out as accurately and in depth as you can. This will help me in completing an accurate picture and thus make our time together effective. Once completed, please bring this form with you to our first consultation.

If there are any questions or concerns please feel free to contact me. Please also be aware that all information discussed is kept in strictest of confidence according to the laws of the Homeopath – patient confidentiality. Although there is a strict code of confidentiality, I am obligated by law to report any suspicion of child abuse.

Thank you for your time and I look forward to meeting you.

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Postal Code \_\_\_\_\_ Email \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_

Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Family Doctor's name and phone number \_\_\_\_\_

Referred by \_\_\_\_\_

**Medical complaints:** please list your child's major complaints in order of importance to you, how long has your child had these complaints, and list the cause of the complaint if you know it.

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**Currently what medications (allopathic or natural) is your child on?**


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**What complementary (massage therapy, nutritionist, etc.) treatments is your child currently following?**


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**Medical Conditions:** *please circle all conditions that you have had in the past or that you currently have:*

Abscesses	Acne	Anaemia	Allergies	Anxiety	Asthma
Cancer	Chicken Pox	Cold Sores	Diabetes	Eczema	Epilepsy
Ear Infections	Frequent Colds	Heart Disease	Hepatitis	HIV/AIDS	Hyperthyroidism
Hypothyroidism	Influenza	Intestinal Worms	Kidney Disease	Leukemia	Lyme Disease
Malaria	Measles	Migraines	Mononucleosis	Multiple Sclerosis	Mumps
Parasites	Pneumonia	Psoriasis	Polyps	Rheumatic Fever	Rubella
Scarlet Fever	Sinusitis	Skin Diseases	Strep Throat	Sunstroke	
Urinary Tract Infection		Tonsillitis	Tuberculosis	Typhoid Fever	Whooping Cough
Yellow Fever					

Other:

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**Surgeries and Major Injuries:** *please list any surgeries your child has undergone or any major injuries your child has suffered*


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**Family History:** *please circle all that apply*

Alcoholism	Allergies	Asthma	Alzheimer's Disease	Anxiety	Cancer
Depression	Dementia	Diabetes	Epilepsy	Gonorrhea	Gout
Hay Fever	Heart Disease	Mental Illness (specify)		Migraines	Paralysis
Pneumonia	Skin Disease	Syphilis	Tuberculosis		

Other: \_\_\_\_\_

**Vaccination History:** *please list any adverse effects from any vaccinations that your child has had*

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**Are there any preceding conditions from which your child has never been well since?**

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**At what age did your child?**

**Roll over:** \_\_\_\_\_

**Sleep through the night:** \_\_\_\_\_

**Walk:** \_\_\_\_\_

**Talk:** \_\_\_\_\_

**Did he/she Breastfeed or Bottlefeed?** \_\_\_\_\_

**Until what age?** \_\_\_\_\_

**What are your child's sleep habits? Position? Routine?** \_\_\_\_\_

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**How does your child play with friends/socialize?** \_\_\_\_\_

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**List what your child likes to do (Lego, dolls, read, colour...)** \_\_\_\_\_

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**Thank you for taking the time to complete this form.  
All information will remain strictly confidential.**

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Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If under 18 years of age, a parent or guardian must sign on your behalf)