

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.

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

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

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:

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

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*

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

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? _____

How does your child play with friends/socialize? _____

List what your child likes to do (Lego, dolls, read, colour...) _____

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

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