HOMEOPATHIC HEALING

Patient's Name _____Date of Birth_____

Age____Today's date _____Email _____

Mother's Name _____Age_____ Father's Name_____ Age_____

Address _____

Cell Phone _____Home Phone _____

Current MD and Phone # _____

How did you hear about Homeopathic Healing? _____

Has your child ever been treated with Homeopathy before? _____

If yes, what remedies? _____

Major Complaints in Order of Importance

Complaint	Since (Age)	Cause
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What Medications is your child currently taking?

Medication and Condition	Since (Age)?	Adverse effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle Any of the Conditions That Have Affected Your Child:

Abscesses	Chicken Pox	Frequent Colds	Rheumatic Fever	Thrush
Allergies	Cold Sores	Measles	Rubella	Tonsillitis
Anemia	Colic	Mood Swings	Scarlet Fever	Tuberculosis
Anxiety	Depression	Mumps	Skin Disease	Typhoid Fever
Arthritis	Diabetes	Mononucleosis	Strep Throat	Warts
Asthma	Eating Disorders	Parasites	Sinusitis	Whooping Cough
Cancer	Eczema	Pneumonia	Sun Stroke	Worms

Any Other Medical Conditions?

_____

Are There any Conditions After Which Your Child Has Never Felt Totally Well Since?

_____

_____

_____

Any Serious Shock, Grief, Disappointment, Fright, Mental Upset or Depression? _____

_____

_____

_____

Number of Previous Pregnancies by Natural Mother _____ # Miscarriages _____

Complications? No Yes If Yes, Please explain _____

_____

_____

Mother's Age at Child's Birth _____

Mother's Health During Pregnancy: List any Bleeding, Nausea, Illness, Physical or Emotional Trauma, Hypertension, Diabetes, Medications, Alcohol, Tobacco or Drug use, etc. _____

_____

_____

Full Term _____ Premature _____ Late _____ Weight **at Birth _____**

Length of Labor _____ Complications **_____**

Growth and Development:

At what age did your child begin:

Teething _____ Walking _____ Sitting _____

Speaking_____ Eating Solid Foods _____

Any issues with your child's growth and development?

_____

_____

Vaccination History:

Measles	**Y**	**N**	**Meningitis**	**Y**	**N**
Mumps	**Y**	**N**	**Hepatitis B**	**Y**	**N**
Rubella	**Y**	**N**	**DTP**	**Y**	**N**
Chicken Pox	**Y**	**N**	**Flu Shot**	**Y**	**N**

Any adverse effects from any of the above? _____

_____

Family Health History

Indicate which of the following ailments have affected your child's relatives:

Alcoholism	**Asthma**	**Diabetes**	**Gout**	**Mental Illness**	**Skin Disease**
Allergies	**Cancer**	**Epilepsy**	**Hay Fever**	**Paralysis**	**STD's**
Arthritis	**Depression**	**Endocrine**	**Heart Disease**	**Pneumonia**	**Tuberculosis**

Relative	**Age if Alive**	**Age @ Death**	**Ailment(s)**
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Maternal			
Grandmother	_____	_____	_____
Grandfather	_____	_____	_____
Aunts/Uncles	_____	_____	_____
Paternal			
Grandmother	_____	_____	_____
Grandfather	_____	_____	_____
Aunts/Uncles	_____	_____	_____

Please list any other important information I should know about your child:

_____

_____

_____

_____