Infant/Child Homeopathic Intake Form

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

Name of Parent(s)/Guardian(S):		
Home Address:		
City:	Prov:	Postal Code:
Home Phone:	Work Phone:	
Cell Phone:		
Email Address:		
Marital Status of Parents:		
Child's Name:		
Child's Date of Birth:	Age:	Sex:
Current Weight:	Current Height:	
Parent's Occupation(S):		
Emergency Contact Name:		
Phone Number:		
How did you hear about our clinic?		
Name, address and phone number of your family physician:		
Has your child been treated by a homeopath before? If yes, please list his/her name:		

What are your main health concerns for your child, and when did each one begin?

Can you trace the origin of any of these concerns to a particular event, accident, illness or mental upset?

What makes your child feel better?

What makes your child feel worse?

List and date any treatments, medications, herbs or remedies used now or in the past:

BIRTH HISTORY:

Child's weight at birth:	Rh blood problem?
Birth complications?	
Delivery was normal?	
Difficult delivery? Explain:	
No. hours in labour:	premature/late delivery:
Caesarean	Epidural
Anything you would like to add?	

MOTHER'S PREGNANCY HISTORY:

INDICATE YOUR USE OF THE FOLLOWING DURING PREGNANCY OR BREAST FEEDING:

Recreational Drugs	X-Rays	Sedatives	Alcohol
Anti-nausea medication	Antibiotics	Green Tea	Coffee
Anti-inflammatories	Laxatives	Black Tea	Steroids
Anti-depressants	Painkillers	Sedatives	Cigarettes

Other:

DEVELOPMENTAL HISTORY OF YOUR CHILD:

Did you breast feed and for how long?
Milk intolerance
Latching difficulties
Other feeding problems (formula/solids)
Co-ordination problems
Growth problems
At what age did your child Crawling Standing Walking Any difficulties?
Speech /language difficulties
Visual/ Hearing difficulties
Dentition Problems
Other developmental difficulties
Vaccination reaction (fever/rash/cold/sweat/etc)

CHILDHOOD DISEASES/INJURIES

Frequent colds	Influenza	Measles	Mumps
Whooping cough	Chicken pox	Croup	Diaper rash
Injuries/burns (Specify)			
Other diseases/accidents/injuries			
Medications administered for any of the above			

OPERATIONS:

1.	At what age?
2.	At what age?
3.	At what age?
Other	
Medications administered for the above	
Was the recovery time normal or excessively long	

CIRCLE ANY OF THE FOLLOWING <u>PAST OR CURRENT</u> CONDITIONS

Jaundice	Colic	Hyperactivity	Sleeping problems	Nervousness
Constipation	Diarrhea	Psoriasis	Behavior problems	Convulsions
Skin Rashes	Heart problems	Lack of energy	Bedwetting	Digestive upset
Ear infection	Learning problems	Allergies	Eczema	Nosebleed
Bleeding gums	Anxiety	Eating disorder	Psoriasis	Depression/sadness
Parasites	Loss of appetite	Excessive appetite	Asthma	Worms
Foul odors (stool/breath/sweat/urine)		Frequent or recurrent illness (specify)		

Other

Medications administered for above

HAVE YOU OBSERVED ANY OF THE FOLLOWING IN YOUR CHILD?

Lack of confidence	Excessive timidity/shyness	Makes friends easily
Prefers to be alone	Likes to be with friends	Prefers one parent
Startles when being put down or going down stairs	Tantrums (biting/kicking/head banging, etc.)	Aversion to being carried/rocked
Better when rocked or carried	Rejects attention when sick	Gets angry easily
Easily startled/noise sensitive	Hard to please	Aggression
Passivity	Affectionate	Violence/cruelty
Averse to being held	Laziness	Resistance to change
Motion sickness	Seems to learn slowly	Easily distracted
Sleeps long hours	Hard to wake in the morning	Needs little sleep
Difficulty in settling for sleep	Prefer cold room	Kicks off covers
Excessive crying	Easily Weepy	Aversion to bathing
Prefers fresh air	Prefers to be wrapped/covered	Wakes with a start
Missing school because of illness or other	Decreased interest in environment	Excessive scratching and picking of skin, ears, nose and/or anus
Poor eye contact	Eyes sensitive to light	Dyslexia
Obstinacy	Oppositional behavior	Disobedience
Lying	Compulsiveness	Grinds teeth
Nail biting	Inclination to masturbate	coldness in limbs or torso

Fears/phobias (specific):

Nightmares (specific):

FOOD (specify):

Cravings
Intolerance
Allergies
Aversion
Other

FAMILY HISTORY:

Relationship	**Age**	**If deceased, age of death**	**Cause of death**	**Diseases**
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister(s)				
Brother(s)				
Aunt(s)				
Uncles(s)				

Homeopathic Disclosure & Informed Consent

I understand that a homeopathic remedy or nutritional supplement may be given with this consultation or be suggested for purchase at a store of my choosing.

If given at the time of consult and needed to be repeated before the next consult, a $10.00 remedy fee (plus shipping if necessary) will be charged.

I confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

I understand that a block of time has been set aside for my private appointment and that a 24-hour notification is required if I must cancel.

I understand that there is a fee of one consult hour ($90.00) for appointments canceled less than 24 hours in advance.

I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment.

I understand that phone and Skype consultations will be billed at the usual hourly rate.

I understand that current fees for single consultations are as follows, but that there may be changes in the fee structure in the future. (Homeoprophylaxis Program prices differ.)

My fee and approximate length of time of appointments:

- Adult New Patient- 2 hours $220.00
- Child New Patient- 1.5 hours $185.00
- Follow up visit- 1 hour $90.00
- Emergency Consults- 15 minute (minimum) $25.00

At this time tax are included

Homeopathy is considered to be an alternative/preventative system of health care and is not intended to be a substitute for allopathic or traditional medicine.

The therapy and information offered should not be construed by you, the client, or any family, friends or caregivers to be a medical diagnosis of any disease or injury.

You should consult with your physician for any serious medical condition and further, you should get at least two medical opinions for such condition.

While Christine Moran DHMHS, RHN has had extensive training in the science and art of Homeopathy and Health Science as well as natural nutrition, she is neither a medical doctor nor a licensed physician.

I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Signature: _____. Date: _____

If patient is under 18 years, parental signature is required.