Infant/Child Homeopathic Intake Form

This information contained herein is strictly confidential.
Please fill out all appropriate pages completely and to the best of your knowledge.

Name of Parent(s)/Guardian(s):		
Address:		
City:	Province:	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:	
Number of Siblings, and Their Ages:		
Parent's Occupation:		
Emergency Contact Name and Phone Number:		
How Did You Hear About This Clinic?		
Name, Address, and Phone Number of Family Physician:		
Has Your Child Been Treated by a Homeopathy Before? If YES, Please List the Name:		

List your child's main health concerns and when they began:

1. _____
   _____
2. _____
   _____
3. _____
   _____

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?

_____

_____

Birth History:
Child's Weight at Birth: _____ Rh Blood Problem: _____

Birth Complications: _____

Delivery was normal or difficult: _____ Explain: _____

Number of Hours in Labour: _____ Premature Delivery: _____

Caesarean: _____ Epidural: _____ Other: _____

Mother's Pregnancy History:
Difficulties becoming pregnant: _____ Weight Gained: _____

Did you experience any of the following:
Nausea_____ Vomiting_____ Anemia_____ Toxemia_____ Diabetes_____

Blood Pressure Changes_____ Eclampsia_____ Other Complications_____

Shocks/Trauma (specify)_____

Emotional Upset (specify)_____

Overall Mental State_____

Post-Partum Depression or Other Complications After Delivery_____

_____

Indicate Your Use of the Following During Pregnancy or Breast Feeding:
Cigarettes _____ Alcohol_____ Recreational Drugs_____ X-Rays_____
Anti-Nausea Medication_____ Antiobiotics_____ Green Tea_____ Coffee_____
Black Tea_____ Sedatives_____ Antidepressants_____ Painkillers_____
Anti-Inflammatories_____ Steroids_____ Laxatives_____
Other _____

Developmental History:

Did you breastfeed? _____ If YES, for how long? _____
Milk intolerance_____ Latching difficulty _____
Other feeding problems (formula/solids) _____
Co-ordination problems _____ Growth problems _____
Crawling/Standing/Walking difficulties_____
Speech/Language difficulties _____ Visual/Hearing difficulties _____
Dentition problems _____ Other Developmental Difficulties _____
Vaccination Reactions (fever/rash/cold/sweats/etc.) _____

Childhood Diseases/Injuries:

Frequent Colds_____ Influenza_____ Measles_____ Mumps_____
Croup or Whooping Cough _____ Chicken Pox_____ Diaper Rashes _____
Injuries/Burns _____
Other diseases/accidents/injuries _____
Medications administered for any of the above _____
_____

Operations:

1_____ Date_____
2 _____ Date _____
Other _____
Medication administered for above _____
Was the recovery time normal or excessively long? _____

Circle any of the following conditions that have been experienced in the past or present:

Jaundice
Hyperactivity
Nervousness
Convulsions
Skin Rashes
Eczema/Psoriasis
Nosebleeds
Loss of Appetite
Anxiety
Lack of Energy
Sleeping Problems
Constipation/Diarrhea
Heart Problems
Bedwetting
Asthma
Bleeding Gums
Excessive Appetite
Depression/Sadness
Colic
Learning Problems
Behaviour Problems
Digestive Upsets
Allergies
Ear Infections
Foul Odours
(stool/breath/sweat/urine)
Eating Disorder
Worms

Frequent of Recurrent Illness (Specify) _____
_____
Other _____
_____
Medications administered for above _____

Have you observed any of the following in your child?

Fears/phobias (specify) _____

Lack of confidence _____ Excessive timidity/shyness _____

Makes friends easily _____ Like to be with friends _____ Prefers to be alone _____

Prefers one parent _____ Aversion to being carried/rocked _____ Tantrums _____

Rejects attention when sick _____ Better when rocked or carried _____

Startles when being put down or going downstairs _____ Hard to please _____

Gets angry easily _____ Easily startles/noise sensitive _____ Aggression _____

Biting/Kicking/head-banging, etc _____ Violence/cruelty _____

Passivity _____ Affectionate _____ Averse to being held _____

Laziness _____ Resistance to change _____ Motion sickness _____

Seems to learn slowly _____ Easily distracted _____ Difficult concentration _____

Sleeps long hours, hard to wake in the morning _____ Needs little sleep _____

Difficulty in settling for sleep _____ Kicks off covers _____ Prefers cold room _____

Excessive crying _____ Easily weepy _____ Aversion to bathing _____ Wakes with start_____

Prefers fresh air _____ Prefers to be wrapped/covered _____ Eyes sensitive to light _____

Nightmares (specify) _____

Poor eye contact _____ Decreased interest in environment _____ Dyslexia _____

Missing school because of illness or other _____ Oppositional behaviour _____

Obstinacy _____ Disobedience _____ Lying _____ Compulsiveness _____

Grinds teeth _____ Nail-biting _____ Inclination to masturbate _____

Excess scratching and picking of skin, ears, nose, and/or anus _____

Coldness in limbs or torso _____

Food cravings, intolerances, allergies, or aversions (specify) _____

_____

Other observations _____

_____

_____

Favourite toys, games, hobbies, activities, sports _____

_____

_____

Academic history and aptitudes _____

_____

_____

Family History:

Relationship	Age	Age at Death	Cause of Death	Diseases
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister(s)				
Brother(s)				
Aunt(s)				
Uncle(s)				