GUIA VITA HOMEOPATHIC CLINIC

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CHILD HOMEOPATHIC INTAKE FORM

Date:	**Referred by:**	
Child's Name:		
Date of Birth:	Age:	Sex: M_____ F______
Height:	Weight:	
Parents: Mother:____________________________________	Father:____________________________	
Address:		
City:	Province:	Postal Code:
Mother's Phone:	Father's Phone:	
Email address:		
Name and phone of Family Physician:		
Name and phone of previous homeopath:		

Child's main health concerns and when did each one begin:

What makes your child feel worse?

What makes makes your child feel better?

Are there any symptoms that accompany the problem?

____

Please check the following conditions your child may have now:

☐Bedwetting
☐Breathing problems
☐Colic
☐Constipation
☐Convulsions
☐Diarrhea
☐Digestive problems
☐Ear infections
☐Eczema/Rashes
☐Hard to please
☐Heart murmur
☐Hyperactivity
☐Jaundice
☐Learning problems
☐Much crying
☐Nervousness
☐No energy
☐Sleeping problems
☐Speech problems
☐Tantrums
☐Teeth problems
☐Vision problems
Other:___________________

Please check the following childhood conditions your child may have had or is having now:

☐Chicken pox
☐Diphtheria
☐Frequent colds
☐German measles
☐Injuries/Burns
☐Measles
☐Whooping cough
☐Accidents
Operations for what:____
Hospitalizations for what:____

Did your child have any of the following vaccinations?

☐Chicken pox
☐Diphtheria
☐ Polio
☐Mumps
☐Pertussis
☐Tetanus
☐Measles
Any adverse reactions to vaccines?___________________________________

Number of bowel movements per day:__________________________________

Child's Birth History:

Birth weight:_____________________ **Rh Blood Problems:___________________**

Any complications during and after delivery?

____

Number of hours in labour:________ Type of delivery:_____________________________

Was this child breastfed?_____________ If yes, for how long?_________________________

What foods were introduced first?

____

Mother's Pregnancy History (Please circle available answer)

Did you have any problems conceiving? Yes / No
Was it a stressful pregnancy? Yes / No
Did you experience any of the following?
Anemia Yes / No Nausea Yes / No
Fatigue Yes / No Vomiting Yes / No
Did you use any of the following during pregnancy?
X-Rays Yes / No Ultrasound Yes / No

Were you on a special diet? If yes, why? ____
How much weight did you gain during pregnancy?______________________________________
What was your emotional state when pregnant with this child?_________________________
During the pregnancy, did you suffer any shocks, traumas, or losses?___________________
Did you have any food cravings or aversions during pregnancy?________________________

The following should be filled out by the child if she/he is between 12 and 16 years of age:

Do you like to be with your friends or prefer to be alone?______________________________
Do you prefer to be with your family?____
Are you confident?____
Do you feel you are different?____
Is it easy for you to become angry?_________ Are you irritable?_________________________
Do you bite your nails?_____________ Do you grind your teeth? ________________________
Any sleeping problems? _________ Do you or did you ever wet the bed?________________
Are you a nervous person?____
Do you feel "hyperactive"?____
Do you feel lazy?____
Do you have difficulties in school?____
Are you unhappy?____
Do you have any fears?____
Do you have any worries?____
What would you like to change about yourself?____

____

____

Please check if you have any of the following ailments in your family history:

☐Alzheimer's	**☐Depression**	**☐Hepatitis**
☐Alcoholism	**☐Gonorrhea**	**☐Mental illness**
☐Cancer	**☐Hypertension**	**☐Skin Disease**
☐Diabetes	**☐Heart Disease**	**☐Tuberculosis**

Other: ___________________

Relationship	Age	If deceased, 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)				