Homeopathy
Holistic Health Care

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CHILD HOMEOPATHIC CONSULTATION FORM

Patient's Name: ______________________________ Date of Birth: (D) __________ /(M) ___________ /(Y) __________

Mother's Name: ____________________________ Father's Name: ______________________________

Address: ____
Street City Postal code

Telephone: Home: ____________________ Work (M.) ___________________ Work (F.) __________________

Telephone: Mobile (M.) __________________________ Mobile (F.) ______________________________

E-mail address: ____

Referred By: ________________ Family Doctor & Phone no.: ____________________________________

Allergies: __________________________

Major complaints in order of importance:

Complaints	Since	Causes

Medications that your child is currently taking?

Medications	Since	Adverse effects

Which of the following conditions has your child had?

Abscesses	Allergies	Anemia	Asthma	Chicken Pox	Cold Sores	Colic
Ear Infections	Eczema	Frequent Colds	Influenza	Measles	Mononucleosis	Mumps
Parasites	Pneumonia	Rheumatic Fever	Rubella	Scarlet Fever	Skin Ailments	Strep Throat
Sinusitis	Sun Stroke	Tonsillitis	Thrush	Travel Sickness	Tuberculosis	Typhoid Fever
Warts	Whooping Cough		Worms			

Any Other Major Conditions? ____
Are there any of the preceding conditions after which your child has not been totally well again? Which ones?
____

Any Major Operations/Injuries?

Operations/Injuries	When	Complications

Vaccination History: Please Circle

Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Meningitis	Yes	No
Hep B	Yes	No

Other: ____

Any Adverse Effects from any of these Vaccinations? Y / N
If yes, please explain: ________________________________

Which of the following ailments, or any other major ailments, have affected your child's relatives:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Mental Illness	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis				

Relative	Age if Alive	Age of Death	Ailments
Mother			
Father			
Brother/Sister			
Son/Daughter			
Grandmother/Grandfather			

Previous pregnancies by natural mother, miscarriages or complications?

____

Mother's age at child birth: ___________ Mother's Health during Pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, etc.

____

Birth History: Full Term _____________ Premature: _____________ Late: ___________ Weight at Birth: ______________

Length of Labour: ___________________ Complications: ____

Age your child began: Sitting ______________ Crawling _______________ Walking _____________ First Words ______________

Feeding: Breast Fed? ___________ How long? __________ Formula? ____________________ Milk/Soy or other? _______________

Food Intolerances? ____ Age began solid foods? _________________________________

Is there any other information that I need to know? ____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (If under 19 years of age, a parent or guardian must sign). I, the undersigned, understand that *Palma Cicco* is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with *Palma Cicco* I am exercising my right to choose an alternative method of treatment through which to address my total health.
As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from *Palma Cicco* and/or *Osteopathic Health Centre Clinic* which will provide me with confirmation of appointments, relevant health information/newsletter, upcoming events, homeopathic and natural heath seminars and learning opportunities. I understand that I can unsubscribe to these emails at any time.

Parent/Guardian Signature: ____ **Date:** ________________________