



**Vaccination History:**

Measles	Yes	No	Any Adverse Effects from any of these Vaccinations? Y / N If yes, please explain: _____
Mumps	Yes	No	
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	
Whooping Cough	Yes	No	
Meningitis	Yes	No	
Hep B	Yes	No	

Other: \_\_\_\_\_

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

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

Relative	Age if alive	Age at 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 personal information will be kept confidential. I consent that from time to time I may receive phone calls/ e-mails/texts from *Palma Cicco and/or any of her other business locations*, which will provide me with confirmation of appointments, relevant health information, newsletters, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails/texts at any time.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_