Green River Natural Health

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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):
Address:
City: Prov: Postal code:
Home phone: Work phone:
Cell phone : E-mail:
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 person and ph#:
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 or her 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 them 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 delivery.....
Caesarean..... Epidural.....
Other.....

MOTHER'S PREGNANCY HISTORY:

Difficulties becoming pregnant.....
Weight gained.....
Did you experience the following:
Nausea..... Vomiting..... Anemia.....Toxemia.….Blood pressure changes…..
Diabetes…..Eclampsia……Other complications…….
Shocks/trauma(specify).....
Emotional upsets(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 medications.....Antibiotics……Green tea…….Coffee…….

Black tea……..Antibiotics.....Sedatives.....Anti-depressants…….Anti-inflammatories…..…Painkillers……Steroids……..Laxatives…….Other.....

DEVELOPMENTAL HISTORY:

Did you breast feed and 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..... Chickenpox..... Diaper rashes.....
Injuries/burns.....Specify:.....
……
Other diseases/accidents/injuries.....
Medications administered for any of the above……..

OPERATIONS:

1.....when.....
2.....when.....
Other.....
Medications administered for above……...
Was the recovery time normal or excessively long…….

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

jaundice	lack of energy	colic
hyperactivity	sleeping problems	learning problems
nervousness	constipation/diarrhea	behaviour problems
convulsions	heart problems	digestive upsets
skin rashes	bedwetting	allergies
eczema/psoriasis	asthma	ear infections
nosebleeds	bleeding gums	foul odours(stool/breath/sweat/urine)
loss of appetite	excessive appetite	eating disorder
anxiety	depression/sadness	worms

frequent or recurrent illness (specify*)

*…….
Other……..

Medications administered for above……..

HAVE YOU OBSERVED ANY OF THE FOLLOWING IN YOUR CHILD?

Fears/phobias (specify).....
Lack of confidence..... Excess timidity/shyness.....Makes friends easily…….
Likes to be with friends…….Prefers to be alone.....Prefers one parent.....Aversion to being carried/ rocked…..Better when rocked or carried……Rejects attention when sick…….Startles when being put down or going down stairs……..
Hard to please…..Gets angry easily..... Easily startled /Noise sensitive…….
Tantrums..... Biting / kicking /head-banging etc.....
Aggression……..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…..Prefers fresh air…….Prefers to be wrapped/covered……. Nightmares(specify)..... Wakes with a start.....
Eyes sensitive to light..... Poor eye contact…… Decreased interest in environment…….
Missing school because of illness or other.....Dyslexia……Oppositional behaviour…….Obstinacy……..Disobedience…….Lying…...Compulsiveness…….
Grinds teeth.....Nail-biting.....Excess scratching and picking of skin, ears, nose and/or anus.....Inclination to masturbate…….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	If deceased, age at death	Cause of death	Diseases
Father				
Paternal Grandfather				
Paternal Grandmother				

Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister (s)				
Brothers (s)				
Aunts (s)				
Uncles (s)				