**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: Other(M.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other (F)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present M.D. and Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major complaints in order of importance:**

|  |  |  |
| --- | --- | --- |
| Complaint | Since | Causes |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medications that your child is currently taking?**

|  |  |  |
| --- | --- | --- |
| Medication | 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 Thrush Travel Sickness Tuberculosis Typhoid Fever Warts Whooping Cough Worms

**Any Other Major Condiditions**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any of the preceding conditions after which your child has not been totally well again?

Which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination History: When:**

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

Tetanus Yes No

Haemophilus Yes No

Pneumococcal Yes No

Meningitis Yes No

DPPT Yes No

Any adverse effects from any of these vaccinations?

**Any Major Operations/Injuries?**

|  |  |  |
| --- | --- | --- |
| Operations/Injury | When | Complications |
|  |  |  |
|  |  |  |

**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

|  |  |  |  |
| --- | --- | --- | --- |
| **Relatives** | **Age if alive** | **Age at death** | **Ailments** |
| Mother |  |  |  |
| Father |  |  |  |
| Brothers |  |  |  |
| Sisters |  |  |  |
| Maternal Grandmother |  |  |  |
| Maternal Grandfather |  |  |  |
| Maternal Aunts/Uncles |  |  |  |
| Paternal Grandmother |  |  |  |
| Paternal Grandfather |  |  |  |
| Paternal Aunts/Uncles |  |  |  |

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did your child begin to:

Sit\_\_\_\_\_\_\_\_\_ Crawl\_\_\_\_\_\_\_\_\_\_ Walk\_\_\_\_\_\_\_\_\_\_ Say 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 Thera Ip 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 Thera Ip, 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 acknowledge that all personal information will be kept confidential.

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_