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	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?____

Vaccination History:

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

Any Adverse Effects from any of these Vaccinations?:
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Haemophilus	Yes	No
Pneumococcal	Yes	No
Meningitis	Yes	No
DPPT	Yes	No

Any Major Operations/Injuries?

Operation/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				

Relative	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.**____

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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?

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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 Catherine R Elliott 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 child's present and future conditions. In consulting with Catherine, I am exercising my right to choose an alternative method of treatment through which to address my child's 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:____