CHILD'S HISTORY

Child's name: _____

Birthdate: _____ Parents' names:_____

Address: _____

City, State, Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

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1. What are the concerns that you would like homeopathy to address?

2. Family history: please indicate which members of the child's family, including him/herself, have been affected by each of these conditions. Include all known blood relatives.

Alcoholism _____

Allergies or asthma: _____

Birth defects: _____

Cancer or tumor: _____

Depression: _____

Diabetes: _____

Drug abuse/dependency: _____

Heart disease/attack:_____

Nervous breakdown:_____

Sexually transmitted diseases
(specify_____

Tuberculosis: _____

Other: _____

3. Medications and supplements currently using:

Homeopathic remedies currently using:

Homeopathic remedies used in the past:

Newborn Section

Please describe any unusual aspects or problems during pregnancy including the Mom's feelings;

Birth; feelings during and after the birth;

Vaccination history: please list vaccines and approximate ages at which the child received them.

Has your child ever had a reaction to a vaccine or a TB tine test? What reaction?

4. Which childhood illnesses has your child had?

What types of crying?

Which breast is the nursing child preferring, if any?

What is the frequency of feeding?

How does the child go to sleep?

Where and when is there perspiration on the child?

Where and when are stools passed?

What is color and consistency of stools?

Tell about urine color and odor and any sediment.

Which part of the body is hot or cold with a fever, illness?

What is the effect of a bath?

How do baby's eyes look?

Tell about any reactions to noises, to machines, cars?

What are the baby's facial expressions during dressing, being lifted, being laid down?

What position is adopted when sleeping?

Infants and Toddlers

What does the child do in his sleep?

What skin discolorations are there?

What skin rashes are there?

What if any involuntary movements are there?

What gestures does the child make?

What preferences are there about clothing items?

How was the child's development in these areas:

Communication (e.g. reaching, signing, talking):

Gross motor (e.g. crawling, walking):

Fine motor (e.g. grasping, drawing):

Has the child had (please check all that apply):

___ problems with teething

___ night terrors

___ trouble sleeping

___ temper tantrums

___ discipline problems

___ problems in school

___ extreme shyness

___ high anxiety

___ bedwetting

___ precocious sexuality

___ violent episodes

___ rigid or ritualistic behavior

___ problems with eating

___ injuries

_____mixing or playing with other children: prefers to be alone; does not play; just sits; likes company and moves around easily; very playful or mischievious; notorious for playing tricks, on children or teachers.

Please feel free to describe any of the above, or any other aspects of your present or past concerns about your child: