H O M E O P A T H Y

your pathway to health

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CONFIDENTIAL PATIENT INFORMATION
Child form

Pre-consultation information

This information must be completed before your appointment.

Homeopathy is a natural system of medicine that stimulates the body to heal itself. It does this by going to the root cause of your symptoms. All imbalances in your body lead to your illness and your symptoms. Your individual feelings and symptoms are the tools I need to help lead me to find your individual homeopathic remedy. Homeopathy follows the natural law of similars, like cures like. Fill in the information on this intake form as completely as possible, so that we can work together to bring your body back to health, that is to say, return you to an overall balanced state. Feel free to contact me at any time for further information.

Linda

General Information

NAME:____

ADDRESS:____

____

POSTAL CODE:____________________________________

PHONE: (home / work/ cell): mom______________________________

PHONE: (home / work/ cell): dad______________________________

E-MAIL: ____

DATE OF BIRTH: year:________month:________day:_______

Referred by:____

Medical doctor's name, location & phone #:______________________________

Signature Parents:______________________Date:______________________

Initial Appointment:

Fill this in completely for your child; ask your partner if they have anything to add.

Injuries/surgeries:

____

____

____

Milestones:

crawl: ______ Age: ______ speaking: ______ Age: ______
walk: ______ Age: ______ Type: ______ Age: ______
teething: ______ Age: ______ Type: ______ Age: ______

Vaccination History:

Type: ______ Age: ______ Type: ______ Age: ______

Adverse effects from vaccines? Yes / no

____

Patient Information

MAJOR MEDICAL COMPLAINTS IN ORDER OF IMPORTANCE

	SINCE	CAUSES

WHAT MEDICATIONS DOES YOUR CHILD TAKE?

	SINCE	ANY ADVERSE EFFECTS ON YOU

WHAT TREATMENTS OR THERAPIES DOES YOUR CHILD FOLLOW?

	SINCE	RESULTS

CLE EACH OF THE FOLLOWING CONDITIONS YOUR CHILD HAS HAD:

Abscesses, Allergies, Anemia, Anxiety Disorder, Asthma, Cancer, Chicken pox, Cold Sores, Depression, Diabetes, Eating disorder, Eczema, Epilepsy, Frequent Colds, Hay Fever, Heart Disease, Influenza, Kidney Disease, Leukemia, Learning Disabilities, Measles, Mononucleosis, Mood Disorder, Mumps, Parasites, Pneumonia, Rheumatic Fever, Rubella, Scarlet fever, Sexual Abuse, Skin Diseases, Strep Throat, Sinusitis, Sun Stroke, Tonsillitis, Whooping Cough, Worms.

ANY OTHER MAJOR CONDITIONS: ____

ARE THERE ANY CONDITIONS AFTER WHICH YOUR CHILD NEVER TOTALLY WAS WELL AGAIN? WHICH ONE (S)?

____

ANY OPERATIONS?	WHEN	COMPLICATIONS

IS YOUR CHILD CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN (S)?

WHO	FOR WHAT CONDITIONS?	TREATMENT

HAS YOUR CHILD BEEN TREATED WITH HOMEOPATHY BEFORE? Yes / No

HOMEOPATH: __________________ WHEN:________________REMEDIES:________________________________

____

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION IN YOUR CHILD TO ANY PARTICULAR CIRCUMSTANCE (e.g. ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, ETC.)

____

____

____

HAS YOUR CHILD HAD ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

____

____

____

TYPICAL BREAKFAST / LUNCH / DINNER / SNACKS: (please give me a 3 day sample)

Day 1:____

Day 2: ____

Day 3:____

ANY SENSITIVITY TO MEDICATION?

____

LIST ALL SUPPLEMENTS YOUR CHILD TAKES:

____

PLEASE MENTION ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CHILD'S CASE:
____

____

Health History of Relatives

Alcoholism, Allergies, Arthritis, Anemia, Asthma, Cancer, Depression, Diabetes, Eczema, Epilepsy, Gonorrhea, Gout, Hay Fever, Heart Disease, High Blood Pressure, Mental Illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS: ______________________________

Your Family Health History: alive or deceased age major ailments

Mother____

Father____

Sisters____

Brothers____

Maternal grand-mother____

Maternal grand-father____

Maternal aunts____

Maternal uncles____

Paternal grand-mother____

Paternal grand-father____

Paternal aunts____

Paternal uncles____

Thank you for taking the time to complete this form.

All information contained herein will remain strictly confidential.

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 Linda Fraser Waldmann 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 Linda Fraser Waldmann, 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.

Parent Signature:_________________________Date:______________________________

Witness:_______________________________________