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New Client Registration for Children

Child's Name:

Age:

Birthdate:

Sex:

Address:

City:

State:

Zip Code:

Home Phone:

Work Phone:

Email:

Mother's Name:

Father's Name:

Do you have a Skype account and a computer webcam?

Health History

Child's Name:

Date:

Please take a minute and list the main complaint(s) for your child that bring you to homeopathic treatment, as well as any other complaints your child is currently suffering or have suffered from in the recent past. These can be mental and/or emotional complaints, as well as physical complaints.

1.

2.

- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

We need to know about your family's medical history (i.e. health issues of parents, brothers and sisters, as well as grandparents). Please mark which of the follow conditions your child or any of your child's relatives have had. Indicate with an "s" for self and an "f" for a family member. For example: Arthritis...F & S or Arthritis... F

Abscesses
 Alcoholism
 Amnesia
 Anxiety
 Anemia
 Arthritis/gout
 Asthma
 Autoimmune Diseases

Bleeding
 Blood Pressure (high) Hyper
 Blood Pressure (low) Hypo

Cancer
 Crohn's Disease
 Cold Sores

Depression
 Diabetes
 Drug Addictions

Emphysema
 Epilepsy
 Gonorrhea

Hay Fever
 Headaches, Chronic

Heart Disease
 Hepatitis
 Herpes

Insanity
 Irritable Bowel Syndrome
 Kidney/Bladder Disease
 Leukemia

Malaria
 Measles
 Migraine
 Miscarriage
 Mononucleosis
 Mumps

Paralysis
 Parasites
 Pelvic Inflammatory Disease
 Pleurisy
 Pneumonia

Rubella
 Prostatitis
 Rheumatic Fever

Scarlet Fever

Sexual Abuse
Skin Disease
Strep Throat
Sinusitis
Sunstroke
Stroke
Syphilis

Thyroid
Tonsillitis

Tuberculosis
Typhoid

Ulcers
Venereal Disease
Warts
Whooping Cough
Worms
Yellow Fever

Please provide a list all Prescription and Over-the-Counter Medications your child is taking and for what condition he/she is taking them.

Medication name and reason for taking:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Please list all Vitamins, Herbs and other Supplements and for what condition your child is taking them.

- 1.
- 2.

- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Finally, please list any alternative or conventional therapies that your child is currently using. Also include the condition(s) or reason(s) that your child is utilizing them. These might include but is not limited to acupuncture, chiropractic, massage, physical therapy, talk therapy or counseling, or energy work, etc.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Please list any surgeries or hospitalizations for your child.

- 1.
- 2.

3.

4.

5.

6.

Thank you!