OSTEOPATHIC HEALTH CENTRE
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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: Mobile (M.) _____ Mobile (F.)_____

E-mail address:

_____

Referred By: _____ Family Doctor & 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?

_____

Any Major Operations/Injuries?

Operation/Injury	When	Complications

Vaccination History:

Measles	Yes	No	Any Adverse Effects from any of these Vaccinations? Y / N
Mumps	Yes	No	If yes, please explain: _____
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	
Whooping Cough	Yes	No	
Meningitis	Yes	No	
Hep B	Yes	No	

Other: _____

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			
Paternal Grandmother			
Paternal Grandfather			

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: _____

Age your child began: Sitting _____ Crawling _____ Walking _____ 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 *Palma Cicco* 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 *Palma Cicco* 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. I consent that from time to time I may receive e-mails from *Palma Cicco* and/or *Osteopathic Health Centre Clinic* which will provide me with confirmation of appointments, relevant health information/newsletter, upcoming events, homeopathic and natural heath seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Parent/Guardian Signature: _____ **Date:** _____