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?
_____

Any Major Operations/Injuries?

Operation/Injury	When	Complications

Vaccination History:

Measles	Yes	No	Any Adverse Effects from any of these Vaccinations?:
Mumps	Yes	No	
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	
Whooping Cough	Yes	No	
Meningitis	Yes	No	
Hep B	Yes	No	

Which of the following ailments, or any major ailments, have affected your child's relatives listed below:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression
Epilepsy	Gonorrhea	Gout	Heart Disease	Mental Illness	Diabetes
Paralysis	Pneumonia	Skin Disease	Syphilis	Tuberculosis	

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._____

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 about?

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 Angelica Necula 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 Angelica Necula, 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 agree that "symptoms" from my child's consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Parent Signature: _____ **Date:** _____

Angelica Necula, Homeopath (HOM)
www.healnow.ca

All clients are required to agree to the following Release and Liability Waiver which is effective for all visits.

By signing below, I acknowledge and agree that:

- Homeopaths do not diagnose conditions.
- The sole purpose of homeopathic remedies is to balance, harmonize, release and heal on all three levels (physical, mental, emotional).
- I understand that some bodily functions may temporarily energetically be affected as a result of shifting energy within my body and I agree that this is a natural occurrence (E.g. feeling more tired) or heighten current symptoms (totally normal body reaction, as part of the healing process), or old symptoms coming back to the surface.
- Treatment/s will not replace conventional medical diagnosis or treatment. I will continue taking medication prescribed by a licensed medical physician and will continue to follow his/her instructions.
- I release the homeopath from all legal liability during my participation in Homeopathic treatment/s.
- All information received by me from the homeopath is accepted with full knowledge that any action taken by me as a result of the information received is my complete responsibility.

Please Print Name_____Signature

Address_____

Date _____Email_____

Ph # _____Recommended by_____