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C L A S S I C A L H O M E O P A T H Y
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CHILD INFORMATION FORM

TODAY'S DATE _____

NAME _____ BIRTHDATE _____ AGE _____ GENDER M F

MOTHER'S NAME_____ FATHER'S NAME_____

HOME ADDRESS _____ HOME ADDRESS_____

CITY_____STATE ____ ZIP_____ CITY_____STATE _____ ZIP_____

HOME PHONE _____ HOME PHONE _____
WORK PHONE _____ WORK PHONE _____
CELL PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____ E-MAIL ADDRESS _____
OCCUPATION _____ OCCUPATION _____
SIBLINGS_____ AGE(S)_____ GENDER_____
HOW DID YOU HEAR ABOUT THIS HOMEOPATH?_____

PLEASE LIST YOUR HEALTH CONCERNS:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

HEALTH HISTORY

Please check any of the following that apply and note when they started

_____	AIDS/HIV Infection	_____	Frequent Antibiotic Use	_____	Measles
_____	Allergies	_____	Frequent High Fevers (>102°F)	_____	Mononucleosis
_____	Anemia	_____	Frequent Steroid Use	_____	Mumps
_____	Appendicitis	_____	Genetic Disorder	_____	Neurological Disorder
_____	Arthritis	_____	German Measles	_____	Poor concentration
_____	Asthma	_____	Hayfever	_____	Psoriasis
_____	Awkwardness	_____	Headaches	_____	Restlessness
_____	Birth Defects	_____	Heart Murmur	_____	Rheumatic Fever
_____	Bladder/Urinary Tract Infections	_____	Hepatitis	_____	Scarlet Fever/Scarlatina
_____	Cancer	_____	Herpes/Cold Sores	_____	Seizure Disorder
_____	Chickenpox	_____	Hypoglycemia	_____	Social immaturity
_____	Chronic Ear Infections	_____	Impulsiveness	_____	Talkativeness
_____	Colitis/Crohn's Disease	_____	Inactivity	_____	Tantrums
_____	Depression	_____	Inconsistency	_____	Thumb Sucking
_____	Developmental Delay	_____	Irritability		Until what age? _____
_____	Diabetes	_____	Jaundice	_____	Tuberculosis (TB)
_____	Distractibility	_____	Kidney Infections	_____	Tubes in ears
_____	Eating Disorder	_____	Left/Right Confusion	_____	Whooping Cough
_____	Eczema	_____	Listlessness		
_____	Exposure to Toxic Substances	_____	Lyme Disease		

Other:_____

Review of Systems
Please indicate the following: N= a condition child has NOW P= a condition child has had in the PAST

Skin
Dry _____
Oily _____
Itching _____
Rashes _____
Hives _____
Fungal Infections _____
Bruises Easily _____
Slow Healing _____
Warts _____ Moles_____
Where _____
How Many _____
Nails Soft_____ Break_____

Head
Migraines_____ Headaches_____
Location of pain_____
Worse: Light __ Noise__ Odors__
Head Injury _____
Describe_____
Dizziness _____
Fainting _____
Seizures _____

Eyes
Vision Disturbance _____
Dryness_____ Tearing_____
Pain _____
Styes _____
Infections _____
Sensitive to Light _____

Ears
Discharge _____
Pain_____ Itch_____
Tubes inserted _____
Impaired Hearing _____
Ringing _____

Nose
Seasonal Allergies _____
Drainage _____
Color: Clear___ Yellow___ Green___
Texture: Runny_____ Thick_____
Post Nasal Drip _____
Stuffiness _____
Sneezing _____
Sinus Infections _____
Nosebleeds _____

Throat/Neck
Pain in Throat _____
Glands Enlarged _____
Difficult Swallowing _____
Change in Voice _____
Clears Throat Often _____

Mouth
Dryness___ Excessive Salivation___
Tongue: Sore___ Coated___
Canker Sores _____

Respiratory
Pneumonia _____
Bronchitis _____
Cough _____
Spit up Blood _____
Asthma ____ Wheezing_____
Shortness of Breath _____
Positive TB Test Ever _____

Cardiovascular
Heart Palpitations/Racing _____
Heart Defect _____
Murmur _____
High___ Low___ Blood Pressure
Leg Pains ____ Cramps____
Ankle Swelling _____
Cold Hands_____ Feet_____

Digestion
Bowel Movement _____
X per day: 1-2___ 2-3___ 3-4___ or
X per week: 1-2___ 2-3___ 3-4___
Texture: Dry___ Hard___
Wet/Loose___ Pellets___
Stools with Mucous___ Blood____
Hemorrhoids
Bleeding___ Painful___ Itching___
Fissures/Fistulas _____
Stool Incontinence _____
Very dark stools _____
Very light stools _____
Bowel Disease _____
Liver/Gallbladder Disease _____
Ulcer _____
Heartburn _____
Bloating _____
Belching _____
Gas / Flatus _____
Nausea / Vomiting _____
Pains / Cramps _____

Urinary
Difficult Urination _____
Painful Urination _____
Incontinence/Dribbling _____
Blood in Urine _____
Frequent Urination Day _____
Night _____
Frequent Bladder Infections _____
Bedwetting _____

Muscular/Skeletal
Back Pain _____
Pain in Muscles/Joints/Bones _____
Stiffness/Swelling _____
Muscle Weakness/Tremor _____
Numbness/Tingling _____
Shooting Pain _____
Paralysis _____
Any Side Worse: R___ L___
Ever Broken Bones?
Which_____
Ever Sprained Joints?
Which_____

GENERAL
Energy (scale of 1-10)
1=worst 10=best _____
Best Time of day___ Worst Time ___
Sleep
Good____ Bad____
Wake Easily? Y / N
Why?_____
Frequently?
Difficulty Falling Asleep Y / N
Wake Refreshed Y / N
Snore Y / N Talk Y / N
Grind Teeth Y / N Sleep Walk Y / N
Preferred Sleeping Position_____
Nightmares Y / N

Temperature
Sensitive to: Hot__ Cold__ Both___
Prefer: Inside___ Outside___
Warm blooded___ Cold blooded___
Best Season_____ Worst Season____

Perspiration
Sweat Easily Y / N
Sweat Excessively Y / N
Sweat Very Little Y / N

Appetite
Excessive____ Good____ Poor____
Foods child craves strongly_____
_____
Foods child dislikes strongly_____
_____
Prefers foods Hot__ Warm__ Cold__
Thirst: Excessive __ Good__ Poor__
Prefer drinks: Very Hot___ Hot___
Warm__ Cold__ Ice cold__
Recent Weight Change Y / N

Pregnancy

Nausea _____
Threatened miscarriage _____
High blood pressure _____
Pre-eclampsia _____
Back pain _____

Birth

_____
Induction (pitocin) _____
Long or difficult labor or delivery _____
Please explain: _____
Prematurity _____
Child late _____
Cord around neck _____
Breech delivery _____
Caesarian section with prior labor _____
Scheduled caesarian _____
Rapid delivery _____
Drugs during labor _____
Please list _____

Neonatal

Rh incompatibility _____
Jaundice _____
Long time to produce breathing _____
Weight at birth _____
Height at birth _____
Colic _____
Much crying for no reason _____
Failure to thrive _____
Breast fed _____
How long? _____
Difficulties with nursing? _____

Development

Periods of separation from mother _____
If so, when? _____ How long? _____
Difficulties learning to walk _____
Difficulties learning to speak _____
Teething troubles _____

Vaccination

_____
Fully vaccinated _____
Partially vaccinated _____
Please specify _____
_____
Not vaccinated _____
Any unusual vaccines _____
(e.g. yellow fever, Lyme, smallpox)
Vaccine reaction _____

Past History

Hospitalization(s): _____
_____
_____

Serious Illnesses and Injuries: _____
_____
_____

Date of Last Physical Exam _____
Date of Last Blood Tests_____

Personal Family History:

Please check the "yes" box next to each condition that applies to the child or one of his/her family members. Please indicate to whom the condition applies by writing the word "child" in the relation column, or if a relative, please write: mother, father, sister, brother, aunt, uncle, grandmother or grandfather.

CONDITION	YES	RELATION	PAST (P) / NOW (N)
Alcoholism/Drug Addiction			
Allergies			
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Cancer			
Type?			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Mental Illness			
Osteoporosis			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Other			

Please list the names of your child's health care providers: _____
_____
_____
_____

Please describe your child's living situation (e.g. divorced parents with joint custody) and any tension at home _____
_____

Please list all prescription and over the counter medications that s/he is currently taking:

Medication	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that s/he is currently taking:

Supplement	Dose	Date Started

Please list any severe or life-threatening allergies that your child has: _____
_____

Please Explain_____

Personal Habits

	hours/week (present)	hours/week (past)
Television		
Computer/Video Games		
Video/Movies		

	how much?	how long for?
Soda		
Sweets/Candy		
Coffee/Tea		

Does the child have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:
_____
_____

Does s/he exercise regularly? Yes No
What type? _____