

**CONFIDENTIAL**

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent's name/s: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Postal code: \_\_\_\_\_

Phone # Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Have you ever consulted a homeopath or naturopath? \_\_\_\_\_ When? \_\_\_\_\_

What was his/her name? \_\_\_\_\_

How did you hear about me?: \_\_\_\_\_

Please list your child's main complaints/symptoms/conditions and the date of onset for each one:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Is your child taking any medication? \_\_\_\_\_ Please list:

_____	_____
_____	_____
_____	_____
_____	_____

Has your child been immunized? \_\_\_\_\_

Were there any adverse reactions such as high fever, rashes, unusual crying, vomiting, etc?

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Please circle the conditions that apply to your child, past or present:

Anemia Allergies Asthma Cold sores Eczema Ear infections Frequent colds  
Mononucleosis Mumps Parasites Pneumonia Rheumatic fever Rubella  
Scarlet fever Sexual abuse Strep throat Sinusitis Tonsillitis Thrush  
Travel sickness Tuberculosis Warts Whooping cough Worms

Family Health History:

	Age if alive	Age at death	Ailments
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Please circle any of the conditions that have affected your family:

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes Epilepsy  
Gonorrhea Gout Heart disease Mental illness Pneumonia  
Skin disease Syphilis Tuberculosis

Were there any complications during the pregnancy?

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Were there any complications during labour and delivery?

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