K-W Homeopathic Medicine and Wellness Clinic

CHILD HISTORY

*All information provided is kept in strict confidence

Date: _____

Child's Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** □ **male** □ **female**

Weight: _____ **Height:** _____

Girls: Age at first period: _____

Address: _____

_____

Parents: _____

Mother's Phone: (home) _____ (cell) _____ (work) _____

Mother's E-mail: _____

Father's Phone: (home) _____ (cell) _____ (work) _____

Father's E-mail: _____

Emergency contact: (name) _____ (relationship) _____

telephone: (home) _____ (cell) _____

Primary care physician: (name) _____ (telephone) _____

Address: _____

Referred by: _____

751 King Street West, Suite 310
Kitchener, ON
N2G 1E5

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Tel.: (519) 603-0505
or visit our website at:
www.kwhomeopathicmedicine.com

Main concerns, in the order of priority, and date started:

Can you trace the origin of any present condition to any particular circumstance? (e.g. accident, illness, grief, mental upset, etc.)

_____

Prescription medications, non-prescription medications and health supplements the child is currently taking:

Name	Dosage	Condition treated	Since when

Other treatments or therapies:

Name	Frequency	Since when

Substances the child is using:

Description	**Amount**	**Description**	**Amount**
□ **Alcohol**		□ **Pain Killers**	
□ **Chewing Tobacco**		□ **Recreational Drugs**	
□ **Cigarettes**		□ **Sleeping Pills**	
□ **Coffee**		□ **Tea**	
□ **Laxatives / Purgatives**		□ **Other**	

Allergies: _____

_____

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Medical history

Medical procedures, surgeries, hospitalizations, accidents and major trauma

Date	Description

Vaccinations:

□ **Measles** □ **Mumps** □ **Rubella** □ **Pertussis** □ **Chicken Pox** □ **Flu** □ **Other**

Adverse reactions:_____

Which of the following has the child experienced or is suffering from now:

□ Abortion	□ Colic	□ Goitre	□ Leukaemia	□ Parasites	□ Tonsillitis
□ Alcoholism	□ Constipation	□ Hard to please	□ Malaria	□ Pneumonia	□ Tuberculosis
□ Allergies	□ Convulsions	□ Hay Fever	□ Measles	□ Rheumatic Fever	□ Undescended testicles
□ Anemia	□ Depression	□ Heart Murmur	□ Mental problems	□ Sexual Abuse	□ Urticaria
□ Appendicitis	□ Diabetes	□ Hepatitis	□ Miscarriage	□ Skin Disease	□ Vision Problems
□ Asthma	□ Diarrhea	□ Herpes	□ Mononucleosis	□ Sinusitis	□ Warts
□ Bedwetting	□ Digestive Problems	□ Hypertension	□ Much crying	□ Sleeping Problems	□ Whooping Cough
□ Breathing Problems	□ Ear Infections	□ Influenza	□ Mumps	□ Speech Problems	□ Worms
□ Burns	□ Eczema	□ Injuries	□ Nervousness	□ Strep Throat	□ Yellow Fever
□ Cancer	□ Epilepsy	□ Jaundice	□ Night Terrors	□ Tantrums	□ Other
□ Chicken Pox	□ Frequent Colds	□ Kidney Disease	□ No energy	□ Teeth Problems	
□ Cold Sores	□ Gall Stones	□ Learning Problems	□ Nosebleeds	□ Thyroid problems	

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Child's Birth History

Birth Weight:_____ Rh Blood Problems?_____

Any complications during and/or after delivery? _____

Number of hours in labour:
_____

Was the delivery:

□ Normal	□ Premature	□ Caesarean	□ Forceps aided
□ At home	□ In hospital	□ Drug aided	□ Difficult

Was the child breastfed?_____If yes, for how long?_____

Type of formula used?
_____

At what age was: milk introduced?_____solid foods?_____

What foods were first introduced? _____

Mother's Pregnancy History

Did you have any problems conceiving?_____

Did you have a stressful pregnancy?_____

Did you experience any of the following?

□ Anaemia	□ Fatigue	□ Nausea	□ Vomiting

Did you use any of the following during pregnancy?

□ Alcohol	□ Antibiotics	□ Cigarettes
□ Iron supplements	□ Recreational drugs	□ Sedatives
□ Sleeping pills	□ Other _____	

Did you undergo x-rays? _____ Ultrasound? _____

How much weight did you gain during pregnancy? _____

Did you have any food cravings or aversions during pregnancy? If yes, what were they?
During the pregnancy, did you suffer any shocks, traumas, or losses? If yes, explain

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Family history:

Ailments which may be present in your family history:

□ **Alzheimer's**	□ **Diabetes**	□ **Hypertension**	□ **Mental problems**	□ **Tuberculosis**
□ **Alcoholism**	□ **Depression**	□ **Heart Disease**	□ **Skin Disease**	
□ **Cancer**	□ **Gonorrhoea**	□ **Hepatitis**	□ **Syphilis**	

Relationship	**Age**	**Diseases**	**Age at death**	**Cause of death**
Mother				
Father				
Brother(s)				
Sister(s)				
Children				
Maternal Grandmother				
Grandfather				
Aunts				
Uncles				
Paternal Grandmother				
Grandfather				
Aunts				
Uncles				

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Details about your Child's symptoms:

What triggers the symptoms (mental, emotional and physical symptoms)?

_____

Does anything make the symptoms unique?

_____

What makes the symptoms better (i.e. hot/cold, eating, sleep, time of day)?

_____

What makes the symptoms worse?

_____

Is the child affected by the weather? How?

_____

Perspiration (odour, night sweats, profuse)?

_____

Body temperature:

_____

Sleep (falling asleep, waking, position):

_____

Average energy level during the day (0 = none, 10 = max.): _____

Has the child lost any weight recently? How much? _____

Is there anything else regarding the child's overall condition that we should know?

_____

_____

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Do you give permission to share your child's information with other health care providers for purposes of medical evaluation?

□ yes □ no

_____
(signature of parent or guardian)

How did you hear about K-W Homeopathic Medicine and Wellness Clinic?

□ **Referral from Health Care Practitioner**
□ **Referral from family or friends**
□ **Public Health Talk**
□ **St. Jacobs Farmers' Market**
□ **Other**

□ **Internet** _____
□ **Newspaper** _____
□ **Magazine** _____
□ **Event** _____

_____

Thank you for taking the time to fill out this form!

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