CHILD INTAKE FORM

(Please Print)

PATIENT INFORMATION

Today's date:				
Last name:	First:	Middle:	Parent/Guardian names:	
Birth date: d* / mth /yr	Age:	Sex: M F		
Street address: P.O. box:		Home phone no.: ( )	Other phone no.: ( )	
City:	Province:		Postal Code:	
Referred to clinic by (please check one box):		Family	Friend	Dr.
Hospital	Insurance Plan	Close to home/work	Internet	Workshops/lectures
Name and *ho*e no. of Family Physician:				
Name and phone no. of Homeopath (if you have seen previously):				

IN CASE OF EM*R*ENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	work phone no.: ( )

Vital Statistics

Height:	**Weight:**	**Blood Pressure:**	**Pulse:**	
Allergies:				

HEALTH HISTORY

What is your child's main health concern? When did it start?

Did this concern start after an event, accident or mental upset? Such as shock, worry, dietary, overexertion, weather?

Does anything make it better or worse?

Does he/she have any other health concerns? Please list in order of importance for you.

Please check if your child has ever had any of these conditions:

Abscesses
Anemia
Appendicitis
Arthritis
Asthma
Cancer
Chicken pox
Cold sores
Depression
Diabetes
Eczema
Epilepsy
Gall stones
Goitre
Gonorrhea
Gout
Headaches
Heart trouble
Hypertension
Hepatitis
Herpes
Influenza
Jaundice
Kidney disease
Leukemia
Liver disease
Malaria
Measles
Mental illness
Mononucleosis
Mumps
Nosebleeds
Parasites
Pneumonia
Prostate disease
Rheumatic fever
Sexual abuse
Skin disease
Strep throat
Sinusitis
Stroke
Syphilis
Tonsillitis
Tuberculosis
Warts
Whooping cough
Worms
Yellow fever
Others?

If you have checked out of the above please fill out the following:

Condition:	How many times and when?	How long each time?

List any treatments, medicines, supplements, homeopathic remedies your child is taking.

List any surgeries/medical procedures your child has had.

PRENATAL/NEONATAL HISTORY

Please describe the mother's pregnancy (i.e. difficulty conceiving, nausea, diabetes, hypertension, bleeding, previous miscarriages, excessive weight gain, activity during pregnancy, food cravings etc.)

Please describe any *emotional events that occurred during the pregnancy(i.;e .unplanned pregnancy, job loss ,divorce, move, etc)

Please describe any possible complications of the birth or following the birth.

IMMUNIZATION RECOR*

Please list all Immunizations given to your child and any adverse reactions

FA*ILY HI*T*RY

Please check if these conditions have occurred among the child's relatives and write down who it was.

Allergies	Diabetes	Hypothyroid	Seizures
Anemia	Eczema	Hyperthyroid	Stroke
Asthma	Epilepsy	Kidney Disease	Tuberculosis
Arthritis	Glaucoma	Mental Illness	Malaria
Bleeding Tendency	Gout	Mental Retardation	
Blindness	Heart Disease	Migraines	
Depression	High Blood Pressure	Multiple Sclerosis	

Thank you for taking the time to fill out these forms.
All the information given is confidential.
We look forward to working with you and your child on their journey to health and well-being.
EQUILIBRIUM-HOMEOPATHY