HOMEOPATHY
FOR FAMILIES

Child intake Form

Patient Information

Patient Name: _____ Date of Birth_____
Mother's Name: _____ Father's Name: _____
Address: _____
Phone Number: _____ Work: _____Cell_____
Email: _____
Family Doctor/Pediatrician: _____Phone Number: _____

Current Complaints

Please describe the main complaints you come in with starting with the most important to you.

_____
_____
_____
_____
_____
_____

Medications currently taking?

_____
_____
_____
_____

Medical History- please circle conditions that your child has struggled with

Abscesses Recurring Bronchitis Infections Pneumonia Sun Stroke Coughs
Frequent Colds Hay fever Enuresis Mouth Ulcers Delayed Dentition Vomiting
Allergies Anemia Asthma Cold Sores Colic Constipation Ear infections
Eczema Headaches Influenza Measles Mononucleosis Mumps Parasites
Rheumatic-Fever Rubella Scarlet Fever Skin Ailments Strep Throat
Sinusitis Tonsillitis Thrush Travel Sickness Tuberculosis Typhoid Fever
Warts Whopping Cough Worms

Any other things? _____
_____

Any operations or illnesses that were hospitalized for? Please give the dates.

_____
_____

_____
_____
_____

Vaccination History- Please mark the dates. Circle if difficulty with the vaccination.

_____MEASLES
_____MUMPS
_____RUBELLA/GERMAN MEASLES CHICKEN POX
_____WHOOPING COUH MENINGITIS
_____HEPATITIS B
_____HPV

Explain any adverse reactions to vaccinations

_____
_____
_____
_____

Please state the age your child was when first:

Sitting _____Crawling:_____Walking:_____
First Word:_____Eating Solid foods:_____
Brest Fed? _____How Long?_____Formula?_____
Are there any food intolerances?

_____
_____

Mom's Pregnancy

Mothers health during pregnancy: Please list any bleeding, nausea, illness, physical/emotional trauma, hypertension, diabetes, medications, alcohol/drugs/cigarettes etc .

_____
_____
_____
_____
_____

Did you carry to term? _____ How long was labor? _____
Was labor naturally stimulated or induced? _____
Natural child birth or Cesarean Section? If C/s, Why?

_____
_____
_____

Family Medical History

Please circle if any of these problems are in the family either side?

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes Epilepsy Gonorrhea Gout Heart Disease Mental Illness Skin Disease Syphilis Tuberculosis
Any other major ailment?
_____
_____
_____

Please list the age, and if deceased, the age at that time and cause of death

Mother:_____
Father:_____
Brother(S):_____
Sister(S):_____
Maternal grandmother: _____
Maternal Grandfather :_ _____
Maternal Aunts(S)_____
/Maternal Uncle(S) _____
Paternal Grandfather _____
Paternal Grandmother_____
Paternal aunt(S)_____
Paternal Uncle(S)_____

Homeopathy is considered to be an alternative/preventative system of health care and is not intended to be a substitute for allopathic or traditional medicine. The therapy and information offered should not be construed by you, the client, or any family, friends or caregivers to be a medical diagnosis of any disease or injury. You should consult with your physician for any serious medical condition. I understand that Mary Nunez is not a medical doctor, but a homeopath. I further confirm that all the above information is correct to the best of my knowledge.

Signature of parent or legal guardianship of minor:

_____Date:_____

name printed _____