Renee Edwards, DCHM, BFA

Child Homeopathic Consultation Form

Child's Name:_____ Date of Birth: D_____ M_____ Y_____

Mother's Name:_____

Address:_____
Street City Postal code

Telephone: Home:_____ Work_____ Other_____

E-mail address:_____

Referred By:_____ Present M.D. and Phone no.:_____

Major Complaints in Order of Importance:

Complaint	Since	Causes

Please list any medications your child is currently taking?

Medication	Since	Adverse Effects

What Other Treatments or Regimes Are You Currently Following for your child?

Treatment or Regime	Since	Results

Which Of The Following Conditions has your child had? Please circle

Abscesses, Allergies, Anemia, Asthma, Chicken Pox, Cold Sores, Colic, Ear Infections, Eczema, Frequent Colds, Influenza, Measles, Mononucleosis, Mumps, Parasites, Pneumonia, Rheumatic Fever, Rubella, Scarlet Fever, Skin Ailments, Strep Throat, Sinusitis, Sun Stroke, Tonsillitis, Thrush, Travel Sickness, Tuberculosis, Typhoid Fever, Warts, Whooping Cough, Worms

Any Other Major Conditions?_____

Is there any illness/condition/event after which your child has not been totally well again since? Which Ones?_____

_____

Is your child currently under the care of a physician(s)?

Physician	For What Condition?	Treatments
_____	_____	_____
_____	_____	_____

Any Major Operations or injuries?

Operation/injury	When	Complications

Did your child have any of the following Childhood Illnesses?:

Measles	Yes	No	Have you had any adverse effects from the illness?
Mumps	Yes	No	_____
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	_____
Whooping Cough	Yes	No	

Vaccine History:
Has your child had routine childhood vaccinations?

Measles	Yes	No
Mumps	Yes	No
_____		
Rubella/German Measles	Yes	No
Chicken Pox Yes No		
_____		
Whooping Cough	Yes	No
Meningitis	Yes	No
Hep B	Yes	No

Any Adverse effects from any vaccines?

_____

_____

Indicate below, which of the following ailments, or any other major ailments, which have affected your child's relatives:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Insanity	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis				

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

Were there any previous pregnancies by natural mother, miscarriages or complications? Please list.

_____

_____

Mother's age at child birth:_____ Mother's Health during Pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, etc._____

_____

Birth History: Full Term_____ Premature:_____ Late:_____ Weight at Birth:_____

Length of Labour:_____ Complications:_____

Age your child began: Sitting_____ Crawling_____ Walking_____ First Words_____

Feeding: Breast Fed?_____ How long?_____ Formula?_____ Milk/Soy or other?_____

Food Intolerances?_____ Age began solid foods?_____ Is there any other information that I would need to know?

_____

<u>Medical/Professional Waiver</u>

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Renee Edwards is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Renee Edwards, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential.

Parent's Signature:_____ Date:_____

Witness:_____