CHILD REGISTRATION FORM

It is helpful if both parents are present for the consultation. If this is not possible, a ***letter from the parent not present summarizing issues or concerns*** *can be useful.*

On the day of the consultation, ***please permit your child to choose comfortable clothing****. Choice of dress can be helpful in revealing the child's nature and preferences.*

Child's name____

Last First Middle Initial

Date of Birth: _____________________ **Sex: M F**

Address: ____

Street City State Zip

Child's Brothers & Sisters (please include Dates of Birth): **Child has no brothers/sisters ____**

1.____ 4.____

2. ____ 5.____

3.____ 6.____

Parent's/Guardian's Name: ____

E-mail: ____

Phone: Day: __________________ Evening:_____________________Cell:_______________________

Other Parent's Name:____

E-mail: ____

Address (if different from child's):____

Phone: Day: ____________________ Evening:________________________Cell:__________________________

Name of Person to be contacted in case of emergency: ____

Telephone/cell:______________________________

Address:____

Relationship to Child: ____

If child is in school, Current School and Grade Level:____

How did you learn about us?____

Physician/Primary Care Provider:____

Phone

What do you MOST WANT from homeopathic treatment for your child? _______________________________

____

1. Please list all the child's ALLERGIES (drugs, foods, pollen, ragweed, etc.**) you have been informed of by a medical professional:**

1.____ 4.____

2.____ 5.____

3.____ 6.____

2. Vaccinations (please provide *immunization record*): **Child has never been vaccinated _____**

Has your child ever had a REACTION or PROBLEMS FOLLOWING a VACCINATION? Yes / No

- - - - -> If Yes, please describe:____

____

3. Has your child ever had a REACTION or PROBLEMS FOLLOWING A MEDICATION? Yes No

- - - - -> If Yes, please describe these problems:____________________________________

____

4. Please list all SURGERIES & HOSPITALIZATIONS for your child:

Year	Reason

5. Have you previously sought ALTERNATIVE OR COMPLEMENTARY MEDICAL CARE for your child? Yes No

- - - - -> If Yes, please list names and services sought**:**

1.____

2.____

3.____

6. Please list ALL MEDICATIONS AND SUPPLEMENTS your child is CURRENTLY TAKING (including prescription drugs, nonprescription medicines, homeopathic remedies, herbs, vitamins, mineral supplements, etc.**):**

Name	Date Started	Dosage/ Frequency	Reason

7. Please list all the child's current diagnoses that you have been informed of by a medical professional:

1.____ 5.____

2.____ 6.____

3.____ 7.____

4.____ 8.____

8. Please check ALL CURRENT AND PAST ILLNESSES in the CHILD'S FAMILY and indicate CAUSE OF DEATH where relevant:

[Check here if you don't know anything about the child's family medical history _____]

ILLNESS	Child's Mother	Child's Father	Child's Sister/Brother	Child's Grandparent	Check if CAUSE OF DEATH
Abnormal periods					
Alcohol/Drug Abuse					
Allergies					
Anemia					

ILLNESS	Child's Mother	Child's Father	Child's Sister/Brother	Child's Grandparent	Check if CAUSE OF DEATH
Arthritis/Gout					
Asthma					
Bleeding problems					
Cancer					
Diabetes					
Eczema					
Emphysema					
Epilepsy					
Frequent infections					
Heart trouble					
Hepatitis					
High blood pressure					
Kidney problems					
Mental illness					
Migraines					
Polio					
Pneumonia					
Prostate Problems					
Psoriasis					
Rheumatic fever					
Stomach problems					
Stroke					
Thyroid problems					
Tuberculosis					
Ulcers					
Venereal disease					
Weight problems					

Thank you for your time and cooperation in completing this form!