Nature's Mark Homeopathy

Lori Reeves, HOM, DCHM

613-757-1268

Email: lori@naturesmark.ca

CONFIDENTIAL CHILD PATIENT CONSULTATION FORM

Note to Patient: Determining the proper remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment.

In order to develop an accurate picture of your situation, and to make the most effective use of our time, I request that you complete the following information form as accurately as possible.

Please note that all the information you share is kept in the strictest confidence according to the laws of Homeopath-Patient confidentiality.

Name: ____

Date of Birth: D_______M_______Y____________

Mother's Name: ____________________________ Father's Name: ______________________________

Address: Street____Apt _____ City ____________________

Postal Code _______________________

Telephone: Home: ____________________Work(M)____________________Work(F)_______________

Telephone: Other(M)__________________________Other(F) __________________________________

Email Address: ____

Patient Referred by: ____

Family Doctor

Full Name: ____

Practice Phone: ____

Major complaints in order of importance:

Complaint Since Causes

____

____

____

____

____

Medications that your child is currently taking?

Medication Since Adverse Effects

____

____

____

____

Which of the following conditions has your child had?

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

Any Other Major Conditions? ____

____

Are there any of the preceding conditions after which your child has not been totally well again?

Which ones? ____

Immunizations	**(Circle One)**	**Any Adverse Reactions?**
Measles	YES / NO	YES / NO
Mumps	YES / NO	YES / NO
Rubella/German Measles	YES / NO	YES / NO
Chicken Pox	YES / NO	YES / NO
Whooping Cough	YES / NO	YES / NO
Meningitis	YES / NO	YES / NO
Hep B	YES / NO	YES / NO
Tetanus	YES / NO	YES / NO
Haemophilias	YES / NO	YES / NO
Pneumococcal	YES / NO	YES / NO
DPPT	YES / NO	YES / NO

Any Adverse Effects from any of these Vaccinations?

____

____

____

Any Major Operations/Injuries?

Operation/Injury	When	Complications

____

____

____

____

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

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

FAMILY MEMBER MEDICAL HISTORY

Member	Age if Alive	Age at Death	Ailments
Mother	_____	_____	______________________________________
Father	_____	_____	____________________________________
Sister 1	_____	_____	____________________________________
Sister 2	_____	_____	____________________________________
Brother 1	_____	_____	____________________________________
Brother 2	_____	_____	____________________________________
Maternal Grandmother	____	_____	____________________________________
Maternal Grandfather	_____	_____	____________________________________
Maternal Aunts/Uncles	_____	_____	____________________________________
Paternal Grandmother	_____	_____	____________________________________
Paternal Grandfather	_____	_____	____________________________________
Paternal Aunts/Uncles	_____	_____	____________________________________

Previous pregnancies by natural mother, miscarriages or complications?

____

____

____

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: _________________________________

____

At what age did your child begin to: Sit___________ Crawl___________ Walk______________

Say 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 need to know?

____

____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (If under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Lori Reeves 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 Lori Reeves, 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.

Parents Signature: ____ Date: ______________