happyopathy
HEALING THROUGH HOMEOPATHY

CEASE PATIENT INFORMATION

DATE OF FIRST APPOINTMENT:

Name		
Date of Birth		Male/Female (Delete as appropriate)
Address		
Parents' Names	Mother:	Father:
Parent's Occupations		
Telephone home		
Telephone work		
Telephone mobile		
Email		

Reason for seeking homeopathic treatment now:

Has your child seen a homeopath before?

If yes, for approximately how long?

For what condition were they being treated?

Please list any homeopathic remedies your child has taken in the past:

Is he/she being treated by any other complimentary health practitioners at present? If yes, please give details.

GP's name	
Address	
Telephone	
Current medication	
Give details of any allergies:	

PERSONAL HEALTH HISTORY

Please fill in this section giving as much information as possible, including dates, or your child's age at the relevant points in time.

Childhood infectious diseases:
Vaccinations which prompted adverse reactions:
Major surgical procedures:
Accidents and injuries:
Is your child generally hot or cold? (do they kick the bed sheets off at night or wear jumpers in the summer?)
Please describe your child's preference for a particular type of weather or environment.
Please describe any food or drink which your child strongly desires or dislikes. Do any foods upset him/her?
Does your child have any strong fears or phobias?

FAMILY MEDICAL HISTORY

Please describe any diseases suffered by members of your family, even if hey are not serious, and causes of death, if known.

Mother	Father
Brothers/Sisters	
Aunts/Uncles	Aunts/Uncles
Maternal Grandmother	Paternal Grandmother
Maternal Grandfather	Paternal Grandfather

VACCINATION HISTORY

Please indicate the vaccination history of the patient and his/her parents during the outlined time periods. Please give the name of the vaccine received and the dates, if known. Continue overleaf if needed.

	MOTHER	FATHER	PATIENT
PRE-CONCEPTION			
PREGNANCY			
BREASTFEEDING			
DURING PATIENT'S LIFETIME			

DISEASE HISTORY
Please indicate any diseases, which may have caused a lasting disruption:

	MOTHER	FATHER	PATIENT
PRE-CONCEPTION			
PREGNANCY			
BREASTFEEDING			
DURING PATIENT'S LIFETIME			

MEDICATION HISTORY

Please tick the appropriate box below to indicate which of the following specific medications has been taken by the patient or his/her parents:

	Father before conception	Mother before conception	Mother during pregnancy	Mother during breastfeeding	Duirng patient's lifetime
Malaria prevention: Malarone, Lariam					
Ultrasound, CT-scan, MRI					
Dental treatments (eg Amalgam fillings, anaesthesia					
Injection between 28-30 weeks with Anti-Rhesus (D) globulin					
Chronic medication for asthma, epilepsy, ulcerative colitis etc					
Anti-hypertensives (eg Nifedipine)					
Cortisone ointment					
Antihistamines					
Medication to prevent vomiting					
Antacids					
Iron against anemia					
Iron injections during pregnancy					
Vaginal tablets against fungal infections (eg Canesten)					
Injections for lung maturation					
Contraction inhibitors					

Please outline any other medication below: (*eg: antibiotics, sleeping pills, reflux medication, anaesthesia, research with contrast medium, anti-diarrheal agents etc)*

	MOTHER	FATHER	PATIENT
PRE-CONCEPTION			
PREGNANCY			
BREASTFEEDING			
DURING PATIENT'S LIFETIME			

OTHER

Please indicate if any of the below have been present in the history of the patient or his/her parents:

	Father before conception	Mother before conception	Mother during pregnancy	Mother during breastfeeding	Duirng patient's lifetime
Strong emotional events, with or without the administration of sedative drugs					
Use of alcohol					
Smoking					
Use of aspartame					
New vinyl in the bedrooms, or other rooms in the house					
Cooking in aluminium pans					
Induction cooking					
Often travelling by plane					
Frequent use of mobile phone or DECT					
Wireless internet at home					

DURING LABOUR

Please tick any of the below medications which were used by the patient's mother during labour, and give names of medication if known:

[ ] Labour Augmentation/Induction.....
[ ] Pain relievers.....
[ ] Anaesthesia.....
[ ] Sedatives.....
[ ] Sleep medication.....
[ ] Other medication.....

CURRENT SITUATION

Please indicate which products are currently used by the patient, or have been used regularly in the past. Please give names if known:

[ ] Deodorant: which type?.....
[ ] Nasal Spray: (Otrivin, Flixonase).....
[ ] Paracetamol (acetaminophen)
[ ] Use of the microwave
[ ] Other products or medication:.....