



Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  M  F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

<b>Parents:</b>		
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Mother's Phone:</b>		<b>Father's Phone:</b>
<b>Family Physician:</b>		<b>Phone:</b>
<b>E-mail address:</b> _____		
Would you like to be added to our mailing list to receive special offers and event notices? Yes ___ No ___		
How did you hear about OCHM Student Clinic?		
Referral: _____ Newspaper: _____ Public Health Talk: _____ Internet/Website: _____ Other: _____		
<b><u>Child's main health concerns:</u></b>		
When did this problem begin? Did anything happen in the child's life during this time?		
What makes the problem worse?		
What time of day or night is the problem the worst?		
Are there any symptoms that accompany the problem?		

**Please check the following conditions your child may have now:**

- |                                             |                                            |                                            |
|---------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> Eczema / rashes   | <input type="checkbox"/> No Energy         |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hard to please    | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Speech Problems   |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Tantrums          |
| <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Jaundice          | <input type="checkbox"/> Teeth Problems    |
| <input type="checkbox"/> Diarrhoea          | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Vision Problems   |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Much crying       |                                            |
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Other _____       |

**Please check the following childhood conditions your child may have had or is having now:**

- |                                           |                                         |                                         |
|-------------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> German Measles | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diphtheria       | <input type="checkbox"/> Injuries/Burns | <input type="checkbox"/> Accidents      |
| <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Measles        |                                         |
| <input type="checkbox"/> Operations       | for what: _____                         |                                         |
| <input type="checkbox"/> Hospitalisations | for what: _____                         |                                         |

**Vaccinations:**

- |                                     |                                    |                                      |
|-------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Mumps     | <input type="checkbox"/> Tetanus     |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Measles    | <input type="checkbox"/> Polio     |                                      |

Any adverse reactions to vaccines? \_\_\_\_\_

Number of bowel movements per day: \_\_\_\_\_

**ONTARIO  
COLLEGE OF  
HOMEOPATHIC  
MEDICINE**



**CHILD'S BIRTH HISTORY:**

<b>Birth Weight:</b>	<b>Rh Blood Problems?</b>		
<b>Any complications during and after delivery?</b>			
<b>Number of hours in labour:</b>			
<b>Was the delivery:</b>			
<input type="checkbox"/> Normal	<input type="checkbox"/> Premature	<input type="checkbox"/> Caesarean	<input type="checkbox"/> Forceps Aided
<input type="checkbox"/> At Home	<input type="checkbox"/> In Hospital	<input type="checkbox"/> Drug Aided	<input type="checkbox"/> Difficult
<b>Was this child breastfed?</b>	<b>If yes, for how long?</b>		
<b>Type of formula used:</b>			
<b>When did the child start eating solid foods?</b>			
<b>What foods were introduced first?</b>			

**MOTHER'S PREGNANCY HISTORY (please circle applicable answer):**

<b>Did you have any problems conceiving?</b>	Yes / No		
<b>Was it a stressful pregnancy?</b>	Yes / No		
<b>Did you experience any of the following?:</b>			
Anaemia: Yes / No	Fatigue: Yes / No	Nausea: Yes / No	Vomiting: Yes / No
<b>Did you use any of the following during pregnancy?:</b>			
Alcohol: Yes / No	Antibiotics: Yes / No	Cigarettes: Yes / No	
Iron Supplements: Yes / No	Recreational Drugs: Yes / No	Sedatives: Yes / No	
		Sleeping Pills: Yes / No	
<b>Did you undergo the following procedures during pregnancy?:</b>			
X-rays: Yes / No	Ultrasound: Yes / No		
<b>Were you on a special diet? If yes, why?</b>			
<b>How much weight did you gain during pregnancy?</b>			
<b>What was your emotional state when pregnant with this child?</b>			
<b>During the pregnancy, did you suffer any shocks, traumas, or losses?</b>			
<b>Did you have any food cravings or aversions during pregnancy?</b>			

**THE FOLLOWING SHOULD BE FILLED OUT BY THE CHILD IF HE/SHE IS BETWEEN 12 AND 16 YEARS OF AGE:**

<b>Do you like to be with your friends or prefer to be alone?</b>	
<b>Do you prefer to be with your family?</b>	
<b>Are you confident?</b>	
<b>Do you feel you are different?</b>	
<b>Is it easy for you to become angry?</b>	<b>Are you irritable?</b>
<b>Do you bite your nails?</b>	<b>Do you grind your teeth?</b>
<b>Any sleeping problems?</b>	<b>Do you or did you ever wet the bed?</b>
<b>Are you a nervous person?</b>	
<b>Do you feel "hyperactive"?</b>	
<b>Do you feel lazy?</b>	
<b>Do you have difficulties in school?</b>	
<b>Are you unhappy?</b>	
<b>Do you have any fears?</b>	
<b>Do you have any worries?</b>	
<b>What would you like to change about yourself?</b>	

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## ***FAMILY HISTORY***

**Please check any of the following ailments which may be present in your family history:**

Alzheimer's \_\_\_      Alcoholism \_\_\_      Cancer \_\_\_      Diabetes \_\_\_      Depression \_\_\_  
 Gonorrhoea \_\_\_      Hypertension \_\_\_      Heart Disease \_\_\_      Hepatitis \_\_\_      Mental problems \_\_\_  
 Skin Disease \_\_\_      Syphilis \_\_\_      Tuberculosis \_\_\_      Other: \_\_\_\_\_

Relationship	Age	If deceased, age at death	Cause of Death	Diseases
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister (s)				
Brother (s)				

**Please list the name and phone number of your family physician:**

\_\_\_\_\_

**Has the child been treated by a Homeopath before?** \_\_\_\_\_

**If yes, what is his/her name?** \_\_\_\_\_