Lisa Decandia,HOM,DSHM, MSc Balanced Health Care 416-441-9222

Child Homeopathic Consultation Form

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

Mother's Name:_____ Father's Name:_____

Address:_____
Street City Postal code

Telephone: Home:_____ Work(M.)_____ Work(F.)_____

Telephone: Other(M.)_____ Other (F.)_____

E-mail address:_____

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

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	Scarlet 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?_____

Vaccination History:

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
Tetanus	Yes	No
Haemophilus	Yes	No
Pneumococcal	Yes	No
Meningitis	Yes	No
DPPT	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

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
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 Lisa Decandia is a homeopathic practitioner of classical homeopathy 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 Lisa Decandia, 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 agree that "symptoms" from my child's consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Lisa Decandia and/or Balanced Health Care which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Parent Signature:_____ Date:_____

Witness:_____