Shenandoah Homeopathy

Personal History Intake Form

Date: ___________________________

Name of the
Child:____

Names of the Parents:

____

Names of Siblings (Include Ages):

____

____

____

____

____

Address:____

City:_________________________________ State:________

Zip:________________________

Phone:____

Email address:____

What are the main concerns you wish to address?

1.____

2.____

3.____

What makes the concern better?

What makes the concern worse?

Is there a favorite food that your child enjoys?

What food or drink does your child dislike ?

Would you say your child is thirsty? If so what is a favorite drink?

Does your child prefer to be warm or cool?

____

What position does your child sleep in at night? Does your child prefer to be covered or uncovered?

____
____
____

When your child is upset, does he/she prefer to be held or left alone?

____
____
____

How does your child act when he/she is angry?

____
____
____

Does your child like to play alone, with a group, or with one other child?

____
____
____

Would you say your child is shy around new people?

____
____
____

Where there any major trauma or event that affected your child emotional in the past?

____
____
____

Child's Health:

Has your child had any of the following illnesses? Check all that apply:

Mumps___ Measles ____ Chicken-pox ____ Polio ____ Glandular fever ____
Mononucleosis_____ Pneumonia____ Eczema____ Asthma____

Cancer_____ Tuberculosis____ Gonorrhea____

If you child has had any of the following immunizations, place an (X) on the appropriate line and/or give the (approximate) year:

Year Immunizations
______ Mumps
______ Measles
______ Chicken Pox
______ Hepatitis
Year Immunizations
______ Smallpox
______Tetanus
______ Polio
______ Flu
Other: ____

Has your child ever had any reactions to vaccination?

Yes No

If Yes, describe:
____
____

Current medications, if any:
____

____

Operations or Major Injuries, if any:
1.____when______________

2.____when______________

3.____when______________

Other____

Does your child have any allergies? If yes, please list:
____
____
____

Has your child had any of the following? Check any that apply:

jaundice____ hyperactivity____ nervousness____ convulsions____ skin rashes____
asthma____
lack of energy____ sleeping problems____ tantrums____
heart problems____ vision problems____ behavior problems____ allergies____
colic____
learning problems____ constipation/diarrhea____
digestive upsets____
speech problems____ eczema/psoriasis____ bedwetting____
frequent or recurrent illnesses_____
ear infections____
croup____
injuries/burns____

explain:____

____

Other: ____

Mother's pregnancy

Did you have any difficulty conceiving? ____Yes ____No Describe any problems you had during pregnancy:

____
____
____

Did you take any medication during your pregnancy?

____

Did you have any medication during labor and delivery?

____

Describe your emotional state during pregnancy, including any major stresses that you had:

____
____
____
____

Check all that apply to describe your labor:

____Vaginal delivery ____Caesarian section ____Forceps delivery ____Used suction
____Episiotomy ____Epidural ____Analgesics ____Fetal distress ____Water birth
____Home birth ____Had midwife

Please describe any complications during labor:

____

____

Did you breast feed?

____Yes

_____No
If Yes, for how long?: ______________________

Thank you!