C&C Homeopathy Education

Laura Carlsson, C. Hom

Offering homeopathic consultations, and monthly educational classes

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candchomeopathyeducation.com

Consultations:
$40/initial
$20/follow-up

Health Profile

Child's Name____
Child's Date of Birth (DOB) _______________________ Child's Age _____________ Child's Sex _________
Child's Current Weight _____________ Height __________ Known Allergies _______________________
Child's Place of Birth ____
Child's School Name ____ Grade Level ____________
Parent/Guardian 1 Name ______________________________Relation to Child? __________________
Address ____________________________City _______________ State _______ Zip Code ___________
Phone (home)_______________________________ (other) ___________________________________
Email: ____
Parent/Guardian 2 Name ______________________________Relation to Child? __________________
Address ____________________________City _______________ State _______ Zip Code ___________
Phone (home)_______________________________ (other) ___________________________________
Email: ____
Marital Status of Parents ____
Doctor Name _______________________ Address _________________ Phone Number ____________
How did you hear about us? _______________________Who referred you? ________________________
Are you familiar with, or have you ever had Homeopathic or Naturopathic Therapies?
____
____

CHILD'S CHIEF COMPLAINTS: In your opinion, what are the most important health problems? List as many as you can in order of severity:
1)__________________________ 4)______________________________
2)__________________________ 5)______________________________
3)__________________________ 6)______________________________
Explain ____
____
____

To analyze your case, very specific information is needed to come up with homeopathic remedies, herbal tinctures and other things to support you. Please take the time to fill this out and return it as soon as you can.

Birth History:
Vaginal _____ C-Section _____ Reason for C-Section ______ Birth Weight ____________ Weeks_________
Full term/ Preterm/ APGARS? Explain____

Mom's Pregnancy:
Uncomplicated ______ Diabetes _______ Early Labor ______ Thyroid Problems _______ Bleeding ________
Hypermesis (excessive vomiting) ______ Pre-eclampsia ______ Physical/Emotional Trauma ______________

Post Natal Complications:
None _____ Infections _____ Jaundice ____ Gastrointestinal _____ Respiratory _______ Cardiac _______
Other __________________________ Hospitalized. How Long? _____________________________________

Developmental History:

Rolled Over at __________ Talked at __________ Sat up at __________ Crawled at __________
Walked at __________ Solid Food at __________ Breastfed __________ Formula __________
Has (s)he stopped or had regression of speech? ____

Medical History:

Allergies_____Asthma_____Breath-holding spells _____Chickenpox _____Colic _____Dehydration _____
Ear Infections _____ Eczema _____ Encephalitis _____ Frequent colds _____ Measles _____
Meningitis _____ Syncope (passing out) _____ Pneumonia _____ Seizures _____ Strep Throat _____
Tonsillitis____Previous Surgeries including dates____

Symptoms:

Hives _____ Cries easily _____ Nose bleeds _____ Acne _____ Jaundice _____ Diarrhea _____
Wheezing _____ Vomiting spells _____ Joint pains _____ High fevers _____ Dizziness _____ Anemia _____
Low Appetite _____ Fatigue _____ Constipation _____ Frequent Urination _____ Stomach Aches _____
Headaches _____ Warts _____ Hair Loss _____ Cough _____ Rashes _____ Other ___________________

Immunizations:

Please list all vaccines and dates on the back of this page or include the child's vaccine record.
Any reactions to immunizations? ____
Has child had the SARS-CoV-2 Vaccine? ______ Date ________ Brand ________ Boosters, if any ________

Medications/Supplements:

Current Medications and what dosage? ____
Current Supplements and how often? ____

Family History:

Relation	Age	State of Health	Age at Death	Cause of Death	List which relatives, if any, had the following conditions:
Father					Allergies ____________ Aneurysm ____________ Anxiety ____________ Asthma ___________ Arthritis/Gout ____________ Autism ____________
Mother					Brain Tumor __________ Cancer (type) _____________ Cerebral Palsy_________
Brother(s)					Chemical Codependency ________ Depression _______ Diabetes __________ Epilepsy ____________
					Gonorrhea ________ Headaches/Migraines __________ Heart Disease ________ High Blood Pressure _________ Kidney Disease ________ Learning Disabilities ________
Sister(s)					Manic Depression _________ Obsessive Compulsive Disorder __________
					Schizophrenia ____________ Syphilis ____________ Tics ____________ Tuberculosis ____________

Typical Diet:

Favorite Foods ____
Foods avoided/eliminated ____

Academics:

Areas of Strength _______________________________ Areas of Difficulty _________________________
Teacher Comments ____

Behavior Problems:
Explain ____

Sensitivities:
Sounds ___________ Touch ___________ Smells ___________ Lights ___________ Other _____________

Excessive Fears:
Water ______ Monsters/Ghosts ______ Strangers ______ Being alone ______ Thunder/Storms ______
Dark ______Animals______Whichones?__________________________________Other____________

History of:
Biting ______ Hitting ______ Head-banging ______ Aggressiveness ______ Unable to comfort ______
Odd fascinations ______Bedwetting ______Stuttering ______Teeth grinding at night _____
Teeth grinding in the day ______ Pulling own hair ______ Nursing Difficulty ______ Nail biting ______
Explain ____

Vision/Hearing:
Vision tested? ____________ Findings ____
Hearing tested? ______________ Findings ____

Abnormal Movements:
Excessive turning ____________Hand flapping ____________Other _____________________________

Perspiration:
None ______Heavy ______If heavy, explain ____

Sleep:
Normal ______ Difficulty falling asleep ______ Frequent waking ______ Nightmares ______ Terrors ______
Position:
Side ______ Back ______ Abdomen ______ Arms over head ______ Restless ______ Other ______

Play:
How is his/her play? ____
How are interactions with other children? ____

About Your Child:
• Please describe your child briefly so I can understand temperament, values, goals, interests, hobbies, etc.
Feel free to add anything else here that you think is important or relevant ____________________________
____

Disclaimer:
US law demands this statement: "FOR DIAGNOSIS AND TREATMENT OF DISEASE YOU MUST CONSULT A MEDICAL DOCTOR". The services, therapies and products herein discussed are not intended to diagnose, treat, cure or prevent disease, physical or mental and only intended to educate and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature (parent if child is under 18)
____

Printed Name ____

Date ____