HOMEOPATHIC ENQUIRY FORM - CONFIDENTIAL

Please provide the following information about your child and if possible return to me before the appointment.

NAME: . . . . DATE OF BIRTH: . . . .

POSTAL ADDRESS:. . . . .

. . . .

EMAIL ADDRESS:. . . . .

TELEPHONE: . . . . .MOBILE :. . . . .

NAME & ADDRESS OF

G.P.:. . . . .

. . . .

BRIEF DETAILS ABOUT THE COMPLAINT(S) FOR WHICH YOU ARE SEEKING TREATMENT:

DETAILS OF CURRENT MEDICINES OR TREATMENT:

DETAILS OF PAST MEDICINES OR TREATMENT:

BRIEF DETAILS OF PREGNANCY AND BIRTH:

DETAILS OF ANY CHILDHOOD ILLNESSES / OPERATIONS / ACCIDENTS / SIGNIFICANT LIFE EVENTS (Please give dates/approx age. If you prefer complete as a timeline on a separate sheet)

Apart from the main complaint, please indicate any problems with any of the following using 'R' if recent (within the last year) or 'P' if in the past:

Memory	[ ]	Blood/circulation	[ ]
Concentration	[ ]	Skin conditions	[ ]
Dizzyness, vertigo	[ ]	Boils	[ ]
Fainting	[ ]	Warts	[ ]
Depression	[ ]	Cramps	[ ]
Speech	[ ]	Numbness / tingling	[ ]
Headaches	[ ]	Pins & needles	[ ]
Ears & hearing	[ ]	Glands	[ ]
Eyes & vision	[ ]	Itching	[ ]
Nose & smell	[ ]	Nails	[ ]
Mouth & taste	[ ]	Hernias	[ ]
Face	[ ]	Twitches / trembling	[ ]
Teeth	[ ]	Ulcers	[ ]
Throat	[ ]	Allergies	[ ]
Respiration	[ ]	Sweating	[ ]
Coughs	[ ]	Joints	[ ]
Heart	[ ]	Bones	[ ]
Bowels	[ ]	Bladder	[ ]
Digestion	[ ]	Genitals	[ ]

FAMILY MEDICAL HISTORY Please give details of medical history (if known) of family members. If deceased, state at what age and cause of death if known.

Mother:

Father:

Siblings:

Grandmothers:

Grandfathers:

ANY OTHER INFORMATION YOU THINK MAY BE RELEVANT

If there is anything you don’t want me to ask your child about at the appointment, please let me know here so that we can arrange to talk at another time.