Restore True Health Homeopathy

CLIENT INFORMATION - CHILD

Today's Date:
Full Name:
Birth Date:
Parent Email:
Parent Phone #:
Address: **City:** **State:** **Zip code:**
Age :
Height: **Weight:**
Any Siblings, if so, list names and ages:

Check Box indicating vaccine received and write year received, if possible:

	MMR (Measles, Mumps, Rubella)		Polio
	Tdap (tetanus, diptheria, pertussis)		Influenza (list years taken)
	HPV (Human papillomavirus)		Chickenpox (Varicella)
	Meningococcal		Covid (please provide # doses & brand taken)
	Pneumococcal		Small pox
	Dengue		Shingles
	Hepatitis A		Rabies
	Hepatitis B		Rotavirus
			Other:

Family medical history (parents & grandparents on both sides):

Personal medical history & any past surgeries:

Current OTC medications, doctor prescriptions and supplements taking (list brand names):

When was the child's last high fever (above 101.3)? What were the symptoms at the time?

How often does the child experience a common cold? Does the cold resolve on its own or does it go into secondary infections?

Does the child suffer from any skin issues or had skin issues in the past?

Has the child ever suffered from a concussion? If so, how long ago?

How would you describe the child's personality?

What is the main reason you are seeking homeopathic care for the child?

Has the child ever used homeopathic remedies in the past? If so, which remedy and for what symptom and note which remedy (if any) the child seems to have the best response to:

Please take your time to pause and reflect when answering the following questions/symptoms below. Every question has a purpose; you DO NOT need to remember every detail. Once the form is received, it will be thoroughly looked through and patterns may be seen. Although there are sections of the body being addressed on the questions below, holistic well-being is not 'sectioned'. All the information given will be integrated into the session to get a more in-depth case history. You may notice some connections as you fill in the form. You may notice symptoms started following a medical procedure or an emotional event. This form is just as much to allow you to reflect back on the child's health journey as well as to gather information so the best support can be provided.

Circle the symptoms that apply to each category. This is a general list of symptoms and depending on age of child some won't apply in general. Just circle what definitely is a known symptom.

CARDIOVASCULAR: fatigue, numbness of hand/feet, noises in head or ringing in ear, drowsy, palpitations, sigh frequently/air hunger, increased need for fresh air, swollen ankle(s) worse at night tendency to anemia, smoker, shortness of breath, swelling of legs and ankles, light-headedness, loss of consciousness, little or no joy in life, experiencing loss, experiencing rejection, obesity high C-reactive protein, little or no exercise, chest pain, fatigue/pain in arms/legs, feeling unloved, feeling impatient, feeling rejected, none of the above

BONES and MINERALS: hip and joint pain, receding gums and/or dental cavities, tendency towards slouching, bone loss/osteoporosis, crunching or creaking joints, none of the above

DIGESTION: lower bowel gas several hours after eating, burning stomach sensation relieved by eating, alternating diarrhea/constipation, indigestion, difficult bowel movements, ulcers/colitis/gastritis/IBS, bloating, bad breath, coated tongue, rectal itching, inability to gain weight, international travel, cramping, excessive belching/burping, none of the above

LIVER and GALLBLADDER: pain under right side of rib cage, frequent skin rashes, bitter metallic taste in the morning, bowel movements painful or difficult, low energy/weakness/exhaustion, upset from greasy/fatty foods, frequent headaches, pain between shoulder blades, general feeling of poor health, aching muscles, feeling of nausea, frequent use of laxatives, history of gallbladder issues, history of hepatitis, history of jaundice, sneezing attacks, itchy skin that is worse at night, stools light colored, none of the above

THYROID: insomnia, decreased appetite, increased appetite without gaining weight, trouble gaining weight, increase in weight, highly emotional, night sweats/shakes, inward trembling, eyelids and/or face twitch, can't work under pressure, nervousness, intolerance to heat, flush easily, thin/moist skin, dry/scaly skin, heart palpitation, pulse fast at rest, slow pulse (below 65), irritable and restless, ringing in ear, impaired hearing, mental sluggishness, headaches upon rising that wear off during the day, increased frequency of urination, fatigue easily, sleepy during the day, constipation, hair coarse/falls out, reduced initiative, none of the above

ENVIRONMENT: exposure to fumes (ex: paint, salon, car), skin disorders (ex: psoriasis, hives), live near power lines/mobile masts, mercury fillings (silver ones), use of household chemicals, use pesticides, loss of hair, PC work, none of the above

PITUITARY: increased/decreased sugar tolerance, low blood pressure, headaches, failing memory, bloating of abdomen, weight gain around hips or waist, tendency to ulcers, menstrual disorders, lack of menstruation, none of the above

ADRENALS: dizziness, hair growth on face/body (female), masculine features (female), sugar in urine not diabetes, headaches, increased blood pressure, low blood pressure, chronic fatigue, weakness, exhaustion, respiratory disorders, poor circulation, swollen ankles, bowel disorder, allergies, asthma, brown spots or bronzing skin, crave salt, nails weak/rigid, none of the above

IMMUNITY: child with chronic immune disturbances, enlarged glands, skin irritation/eczema, chronic/acute stress overload, swollen lymph glands, re-current minor infections, throat infections, poor wound healing, slow recovery from illness, boils/styes, cold/flu frequently, bumpy skin on arms, inflamed or bleeding gums, cough with mucus, swollen tongue, dark areas under eyes, sore throat, postnasal drip, ear aches and infections, herpes/cold sores, none of the above.

RESPIRATORY SYSTEM: allergies, wheezing, shortness of breath, grief/sadness/crying/recent loss, chest pain, asthma, chronic cough, excessive mucous, cold/flu, skin issues, none of the above

FILTERING SYSTEM: water retention, fatigue, dizziness, high blood pressure, low blood pressure, fear, feeling insecure, frequent urination, difficult urination, incomplete emptying of bladder, frequent kidney/bladder infections, painful urination, difficulty starting the stream, weakness of the knee, legs nervous at night (involuntary movement), poor memory, lower back pain, kidney stone/problems, ringing in ears, blood in urine, none of the above

FEMALE: long standing depression, low feelings before menstruation, headache before or during menses, pre-menstrual tension, painful breasts, too frequent menstruation, migraine headache, obsessive dietary habits, vaginal discharge, uterine fibroids/cysts, retaining fluid during/before period, unable to trust anyone, unfulfilling occupation, overwhelmed, lack of femininity, painful menses, very easily fatigued, acne worse at menses, menses scanty or misses, periods excessive/long, vaginal dryness, breasts cysts/lumps/mastitis, frequent thrush, feeling inadequate, feeling unloved, feelings of guilt, feeling rejected, loss of control, feeling put down

Any further information about their hormones, please explain below:

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MALE: Tire too easily, urination difficult or dripping, avoid activity, pains on inside of legs or heels, leg nervous at night (involuntary), overwhelmed, lack of energy, migraine headache, incomplete bowel movement, frequent night urination, depression, feeling inadequate, loss of control, none of the above

What type of activities do they do to move their body and elevate their heart rate?

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FOOD DIARY

Please write down all the foods and drinks they consume over an average 2-day period. Include everything they consume from the moment they wake to the moment they fall asleep.

Day 1: _____

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Day 2: _____

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Are there any foods that would be difficult to 'cut out' of their lifestyle?

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How many portions of fruit do they eat a day? 0 1-2 3-5 More than 5

How many portions of vegetables do they eat a day? 0 1-2 3-5 More than 5

How much water do they drink a day? <17oz 17oz 17-34oz 34-68 oz More than 68oz

Is there any additional information you would like to provide?

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Do you confirm you have requested Nutritional Medicine and/or coaching support through Leanne Wasilewski via the New School of Nutritional Medicine? Yes No

FORM OF CONSENT TO TREATMENT: I confirm that I request Nutritional and/or Coaching advice from the New School of Nutritional Medicine. I understand that Leanne Wasilewski is a current student and will get support through the New School of Nutritional Medicine where/when appropriate pertaining to my case.

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Parent Signature Today's Date