Homeopathic Consultation - New Child Client Information

PARENT INFORMATION

Parent's Full Name:

Address: **City:** **State:** **Zip code:**

Email:

Phone Number:

CHILD INFORMATION

Full Name:

Sex: **Age:** **Date of birth:**

Height: **Weight:**

PREGNANCY & BIRTH HISTORY

Pregnancy Complications:

Birth Type (vaginal, C-section, assisted):

Birth Weight:

Was your child breastfed? If yes, how long? **If no, what formula was used?**

Any infancy concerns?

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

Check Box indicating if a vaccine was received and write the year it was 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:

If a vaccine was given, any reaction noticed immediately after the vaccine was given?

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

Personal medical history & any past surgeries:

Current over-the-counter medications, prescription medications, and supplements taking (please include 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 do others typically say about the personality of your 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 seemed to have the best response to:

FORM OF CONSENT TO HOMEOPATHIC CONSULTATION

I voluntarily request homeopathic consultation for my child from Leanne Wasilewski through Restore True Health Homeopathy.

I understand that homeopathy is a holistic system of wellness that seeks to support the body's natural healing processes by considering the individual as a whole, including physical, emotional, and mental aspects of health. Homeopathic consultation is intended to provide individualized homeopathic education and recommendations and is not intended to diagnose, treat, cure, or prevent disease, nor is it a substitute for medical care provided by a licensed physician or other qualified healthcare professional.

I understand that recommendations made during the consultation are based on the information I provide regarding my child's health history, symptoms, and overall well-being. I acknowledge that it is my responsibility to provide accurate and complete information and to notify Leanne Wasilewski of any significant changes in my child's health.

I understand that I am responsible for the healthcare decisions made on behalf of my child and for seeking appropriate medical evaluation or emergency care when necessary.

I understand that all information shared during consultations will be kept confidential except where disclosure is required by law or with my written permission.

By signing below, I acknowledge that I have read and understand the information above and voluntarily consent for my child to receive homeopathic consultation through Restore True Health Homeopathy.

☐ *I acknowledge that I have received and reviewed the Restore True Health Notice of Privacy Practices (HIPAA).*

_____

Parent Signature

_____

Printed Name

_____

Date