PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here to get well. We are here to select the possible medicine for you. In order to do that, we depend on your co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order find all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is useless. Even something that you may think is not connected with your trouble, may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give us the fullest possible information on each point*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential.

THIS QUESTIONNAIRE HAS 8 PARTS :

1. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
2. History of your present illness.
3. About all the parts of your body.
4. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
5. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.
6. About your sleep and dreams.
7. For children or how you were as a child.
8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

Pediatric Registration Form

Child's Name_____ Nickname_____

Birth date_____ Age_____ Sex M F

Names and address of parents

_____ _____

_____ _____

_____ _____

Occupation_____ Occupation_____

Phone (___)_____ (___)_____ Phone (___)_____(___)_____

Names and ages of brothers and sisters_____

Child's school or day care_____ Phone (___)_____

Drug allergies or reactions to medicines_____

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: By signing this document, I hereby authorize the staff of the Hahnemann Medical Clinic, Dr. Nancy Herrick DH (Hon), P.A. and Roger Morrison M.D., to treat my child using homeopathic medicines according to the principles of homeopathic practice. I understand and acknowledge the Hahnemann Medical Clinic staff will base their treatment decisions on the school of homeopathic practice, and if I desire to have my child treated according to the orthodox or allopathic school of medicine, I am free to seek such treatment from another physician. In some cases I may be encourage or required to do so. I understand that Nancy Herrick and Roger Morrison act as homeopathic specialists and not as primary care providers. I understand the Hahnemann Medical Clinic will make the best effort to treat my child but makes no guarantees that their homeopathic treatment will cure my child. I also authorize Hahnemann Medical Clinic to video tape my child's interviews for the use of inter-staff consultation on my child's case and/or for the use of teaching students of homeopathy. I certify that the above information is true and give the examining practitioner permission to contact previous practitioners.

I understand that charges will made and herby agree that I am financially responsible for any such charges.

Signature_____ Date_____

HEALTH QUESTIONAIRE

If this child has ever been bothered with any of the following problems check Yes

Yes No

- ☐ ☐ frequent headaches
- ☐ ☐ eye irritation
- ☐ ☐ eyes crossing
- ☐ ☐ trouble with vision
- ☐ ☐ wears glasses

- ☐ ☐ earaches or running ears
- ☐ ☐ difficulty hearing
- ☐ ☐ pulling or tugging his/her ears
- ☐ ☐ speech impediment

- ☐ ☐ dental problems
- ☐ ☐ sore or bleeding mouth or gums

- ☐ ☐ frequent colds
- ☐ ☐ mouth breathing
- ☐ ☐ recurring nosebleeds

- ☐ ☐ recent sore throat
- ☐ ☐ hoarse voice

- ☐ ☐ wheezing or gasping
- ☐ ☐ coughing spells
- ☐ ☐ shortness of breath while walking or playing
- ☐ ☐ must squat or hunch down often while playing
- ☐ ☐ chest pains

- ☐ ☐ burping or gas
- ☐ ☐ abdominal pain
- ☐ ☐ vomiting
- ☐ ☐ diarrhea
- ☐ ☐ constipation
- ☐ ☐ itching at anus
- ☐ ☐ blood with stools
- ☐ ☐ must have a special diet

Yes No

- ☐ ☐ frequent urination
- ☐ ☐ pain or crying when urinating
- ☐ ☐ brown, black or bloody urine
- ☐ ☐ bedwetting (over 4 years old)
- ☐ ☐ daytime wetting (over 3 years old)
- ☐ ☐ discharge from penis or vagina

- ☐ ☐ marking increase or decrease in appetite
- ☐ ☐ weight loss or gain
- ☐ ☐ rashes/swellings after eating certain foods
- ☐ ☐ hayfever/allergies in spring/to animals etc.
- ☐ ☐ skin rashes or swellings
- ☐ ☐ itching skin
- ☐ ☐ warts
- ☐ ☐ bruises or bleeding problems
- ☐ ☐ accidental poisoning
- ☐ ☐ listless or tired
- ☐ ☐ recurrent fevers
- ☐ ☐ motion sickness
- ☐ ☐ serious accidents/sprains/broken bones

- ☐ ☐ shyness
- ☐ ☐ frequent nightmares
- ☐ ☐ waking often during night
- ☐ ☐ fears
- ☐ ☐ overly clinging
- ☐ ☐ easily upset, crying
- ☐ ☐ temper fits
- ☐ ☐ breaks or throws things
- ☐ ☐ fighting
- ☐ ☐ stealing
- ☐ ☐ lying
- ☐ ☐ nervous or nervous habits
- ☐ ☐ special school or classes
- ☐ ☐ problems at school
- ☐ ☐ problems with the family

Place an (X) in the appropriate column for any illnesses that you or the relatives listed at the left have had.

	Allergies	Anemia	Arthritis	Asthma	Bleeding problems	Cancer or Tumors	Diabetes	Digestive conditions	Drinking or Drug problem	Epilepsy/convulsions	Genetic diseases	Hedaches	Haeat disease	High Blood Pressure	Kidney Disease	Mental Illness	Respiratory illness	Skin conditions	Thyroid Problems	Tuberculosis	Venereal Disease	Other major illness
Mother																						
Father																						
Maternal G. Parents																						
Paternal G. Parents																						
Siblings																						

BIRTH HISTORY

Place of birth (home/name of hospital)_____ City _____State ____

Birth Weight_____

If the child's mother had any of these problems during her pregnancy check Yes, if unsure leave blank

Yes No

- ☐ ☐ High blood pressure
- ☐ ☐ Diabetes or sugar in urine
- ☐ ☐ Albumin or protein in urine
- ☐ ☐ Urinary infection
- ☐ ☐ German (3 day) measles
- ☐ ☐ Gonorrhea or syphilis
- ☐ ☐ Drug or drinking dependency
- ☐ ☐ Frequent cigarettes
- ☐ ☐ Other problems or treatments for illness:

  _____
  _____
  _____

Yes No

- ☐ ☐ Was prenatal care received before the sixth month of pregnancy?
- ☐ ☐ Was this child born premature?
- ☐ ☐ Was the birth difficult?
- ☐ ☐ Was the baby born with forceps, cesarean, bottom first? (Circle)
- ☐ ☐ Did the baby have any problems at birth or need help to start breathing?
- ☐ ☐ Did the baby remain in the hospital longer than the mother?
- ☐ ☐ Was this baby breastfed? Until what age? _____

MEDICAL HISTORY

If this child has ever had any of the following problems check Yes, if unsure leave blank

Yes No

- ☐ ☐ Asthma
- ☐ ☐ Blood disorders (anemia, etc.)
- ☐ ☐ Chicken Pox
- ☐ ☐ Convulsions or fits
- ☐ ☐ Croup
- ☐ ☐ Eczema
- ☐ ☐ Frequent bronchitis
- ☐ ☐ German measles (3 day)

Yes No

- ☐ ☐ Hospitalization or operations (If Yes, write details below)
- ☐ ☐ Measles (10 day)
- ☐ ☐ Mumps
- ☐ ☐ Pneumonia
- ☐ ☐ Rheumatic fever
- ☐ ☐ Scarlet fever
- ☐ ☐ Whooping cough
- ☐ ☐ Worms

Please check the immunizations this child has had by placing an (X) next to the appropriate box and, if you can, write the year they were last given.

Year	Immunization	Year	Immunization
_____	☐DPT (diphtheria, pertussis, tetanus)	_____	☐Smallpox
_____	☐Rubella	_____	☐Tetanus
_____	☐HIB	_____	☐Polio
_____	☐Hepatitis B	_____	☐Typhoid
_____	☐Flu	_____	☐Mumps
_____	☐Measles, Mumps, Rubella (MMR)	_____	☐Other_____

Please list all medications and/or herbal/mineral supplements including dosage: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MAIN COMPLAINTS: (AND DETAILED HISTORY OF THE PRESENT ILLNESS, ONSET AND COURSE WITH DATES).

ORIGIN OF CAUSE : Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, overexposure to cold, heat etc.)?

APPETITE AND THIRST

How is your child's appetite ?

When is he/she hungry ?

What happens if your child has to remain hungry for long ?

How much thirst do they have ?

Any particular time specially thirsty ?

Please put one tick (✓) if they Like/ Dislike the food or if the food disagrees. Put two marks (✓✓) , if they strongly Like / Dislike the food or if the food strongly disagrees.

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Bitter				Eggs			
Salt extra				Spicy food			
Sweet				Meat			
Sour				Fish			
Bread				Cabbage			
Butter				Onions			
Fats				Warm food / drink			
Milk				Cold food / drink			
Coffee				Fruits			
Mud / Chalk				Anything else			

FACTORS THAT AFFECT YOUR CHILD

Below are the list of things that your child are exposed to. Each of these factors may affect him/her in a particular way. Please write in what way they are affected by each of the following. Do they feel worse or better in any way from each of the factors?

For instance take the factor “sun”. Suppose by going in the sun your child gets a headache then write “Headache” opposite to “Sun”.

Take another example If in hot weather your child feels uneasy, then write “Uneasy” opposite to “Hot Weather” in the column.

In this way write if the factor has a significant effect on your child. Especially write the effect each fact has on the main complaints. For instance if main complaint is Asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes worse”.

If the factor makes your child better you can write >.
If the factor makes your child worse you can write <.
IF NOT EFFECT PLEASE LEAVE BLANK.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write. I

	Effect
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunder - storm	
Covering	
Warm bath	
Sun	
Cold bathing	

	Effect
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding in bus, car etc.	
Lying	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	

	Effect
Lying with head low	
Sitting	
Sitting erect	
Standing	
Looking up	
Looking down	
Looking from high places	
Looking from moving object	
Noise	
Sudden Noise	
Music	
Light	
Strong smells	
When constipated	
Before Urine	
During Urine	
After Urine	
Before Menses	
During Menses	
After Menses	
After Sweating	
When Fasting	
After eating	

	Effect
Drinking	
After sexual intercourse	
Dust	
Smoke	
Touch	
Pressure	
Massage	
Tight Clothes	
Before Sleep	
During Sleep	
After Sleep	
After afternoon nap	
Loss of sleep	
Before stools	
During stools	
After stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	

	Effect
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After Weeping	
Consolation / Sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Full Moon / New Moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Biting or chewing	
Blowing Nose	
When alone	
In company	
Physical exertion	
Belching	

	Effect
Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Moonlight	
Opening the mouth	
Smoking	
Hanging the limbs	
Raising the arms	
Near Sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Over eating	
Working in water	
Fanning	

Describe your child's personality:

S L E EP

Dreams? Nightmares? Please explain with details.

Describe your posture in sleep, on the back, side, abdomen etc.

Are they able to sleep in any position ? In which position can't sleep ?

During sleep do you :
Snore? Grind teeth ?
Dribble saliva? Sweat ?
Keep eyes or mouth open ?
Walk ? Talk ? Moan ? Weep ?
Become restless ? Wake up with a jerk ?

Describe if anything else is unusual about sleep : (Sleepy, Sleeplessness, etc. if so when)

How much do they cover?

Do they have to uncover any parts ?

FOR CHILDREN

1) Please tick mark once (✓) if the child has any of the following qualities :

Tick mark twice (✓✓) if they are more intense :

	Tick here		Tick here
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like :-	
Hyperactivity		Biting nails	
Destructiveness		Thumb-sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition - winning spirit		(b) shawls, handkerchieves	
Slibling jealousy		(c) anything else	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness / Indolence	
Telling lies		Sensitive / Emotional	

Please use the back of the page to describe the following:

2)Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also describe the dreams the mother got during pregnancy.

3) Please describe any other aspects you feel are striking about the child.

4) Describe one incident from the child's life when he/she very upset.

PLEASE DESCRIBE EACH OF YOUR CHILD'S COMPLAINTS IN DETAIL.

COMPLAINT NO.	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE