Rose Blanche Wellness Homeopathic Consultation Form

Child Homeopathic Intake Form

Name:_____ Date of Birth: D_____ M_____ Y_____

Parent's Name:_____ Parent's Name:_____

Address:_____
Street City Postal code

Telephone: Home:_____ Work(M.)_____ Work(F.)_____

Telephone: Other(M.)_____ Other (F.)_____

E-mail Address:_____

Referred By:_____ Present M.D. and Phone #:_____

Major complaints in order of importance:

Complaint	Since	Causes

Which medications is your child currently taking?

Medication	Since	Adverse Effects

Which of the following conditions has your child had?

Abscesses Allergies Anemia Asthma Chicken Pox Cold Sores Colic

Ear Infections Eczema Frequent Colds Influenza Measles Mononucleosis Mumps

Parasites Pneumonia Rheumatic Fever Rubella Scarlet Fever Skin Ailments Strep Throat

Sinusitis Sun Stroke Tonsillitis Thrush Travel Sickness Tuberculosis Typhoid Fever Warts Whooping Cough

Any Other Major Conditions?_____

Are there any of the preceding conditions after which your child has not been totally well again?

Which ones?_____

Vaccination History:

Measles	Yes	No	Any Adverse Effects from any of these Vaccinations?
Mumps	Yes	No	
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	
Whooping Cough	Yes	No	
Meningitis	Yes	No	_____
Hep B	Yes	No	
Tetanus	Yes	No	
Haemophiles	Yes	No	
Pneumococcal	Yes	No	
DPPT	Yes	No	

Any major operations/injuries?

Operation/Injury	When	Complications

Which of the following ailments, or any other major ailments, have affected your child's relatives:

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes

Epilepsy Gonorrhea Gout Heart Disease Mental Illness Paralysis

Pneumonia Skin Disease Syphilis Tuberculosis

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child birth:_____

Mother's Health during Pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption,

etc._____

_____

Birth History: Full Term_____ Premature: _____ Late:_____ Weight at Birth:_____
Length of Labor: _____
Complications:_____

At what age did your child begin to: Sit_____ Crawl_____ Walk_____
Say First Words: _____
Feeding: Breast Fed?_____ How long?_____ Formula?_____ Milk/Soy or other?_____

Food Intolerances?_____ Age began solid foods?_____

Is there any other information that I need to know?

_____

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.) I, the undersigned, understand that Ashley Mendoza is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Ashley Mendoza, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Ashley Mendoza and/or Rose Blanche Wellness which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Parent Signature: _____ Date:_____