Vivacious Homeopathy LLC

C-732-983-2283

QUESTIONNAIRE FOR INFANTS AND CHILDREN

First name:	**Last name:**
Mother's name:	**Father's name:**
Date of birth: / /	**Today's date: / /**
Address:	**Sex (Circle):** Male Female
City:	**Height: Weight:**
ZIP:	
Home Telephone:	**Work Telephone:**
Cell Phone:	**Website:**
Emergency contact: (Name, relationship, Address, Tel)	
E-Mail:	**Parent's Occupation(s):**
Contact details of Primary doctor:	
MARITAL STATUS OF PRIMARY CARETAKER (*Circle relevant one*) Single, Married, Gay, Divorced, Separated, Widowed, Domestic partnership	

How did you find out about us? (*Circle all relevant ones*)

Referral / Friend / Website / Online Search / Brochure / Other

If Other, please specify _____

Thank you for taking the time to fill out this questionnaire. It is designed to help us develop a deeper understanding about your complaint, as well as assess your child's overall health. Some of the questions may appear completely unrelated to the reason you are seeking help. However, in Homeopathy, we look at not only the primary complaint, but also consider many factors of your child's growth, development, family background and personality, when deciding on a homeopathic remedy. We help children of all ages. Depending on the age of your child, some questions may not be applicable to your child. Simply leave out those questions.

We look forward to helping you! Please type or write neatly.

You may email filled-up questionnaire OR bring it along with you during your visit.

Section A: MAIN COMPLAINT

Please describe your child's main complaint(s) in as much detail as possible. Note when it started, what makes it better or worse and what treatments you have tried?

Name: _____

Section B: MEDICAL HISTORY

List any medication/ vitamins/ herbs or supplements your child is currently taking:

DRUG	DOSAGE	INDICATION

Please don't forget to bring along any relevant medical records you have available.

List medicines your child has taken frequently in the past or over an extended period of time.

DRUG	DOSAGE	INDICATION

List any surgeries your child had in the past:

DATE	SURGICAL PROCEDURE	REASON

Name: _____

What childhood illness/injuries your child had in the past?

AGE	**ILLNESS/ INJURY**	**REACTION TO ILLNESS e.g.** frequency, reoccurrences, severe, mild, hospitalized, etc
AGE	**CHILDHOOD ILLNESSES**	**REACTION TO ILLNESS, e.g.** frequency, reoccurrences, severe, mild, hospitalized, etc

Has your child had any of the following **illnesses**? Check all that apply:

Mump | Measles | ChickenPox | Polio | Glandular fever| Mononucleosis | Pneumonia | Eczema | Asthma | Tuberculosis | Cancer | Gonorrhea | Other

What all **vaccinations** you had? Check all that apply:

SmallPox / Polio / Mumps / Measles / ChickenPox / Tetanus / Hepatitis / Flu / Other

Have you had any vaccinations in the last year? Yes / No If Yes, describe:

_____

Have you ever had any reactions to vaccination? Yes / No If Yes, describe

_____

Does your child have any **allergies**? If yes, please list:

_____

_____

Name: _____

Section C: General Symptoms

Please **CHECK** the information that applies to you:

1) Is your child? Thirsty / Thirst less / Somewhere in between

2) What does your child like to drink? _____

3) Does he/she? Sip drinks slowly / Gulp drinks down / Neither

4) Does he/she prefer drinks that are? Ice cold / Hot drinks / Room temperature

5) Is your appetite? Ravenous / Average / Small / Increased / Decreased

6) Is your body temperature: Too Hot / Too Cold / Can't stand either / Not significant

7) What weather suits your child best? _____

8) Is there any weather that aggravates your child? _____

9) Is your child's perspiration? Extreme / Profuse / Average / Slight / Not at all

10) Where does your child perspire from? _____

11) Please describe the odor of your perspiration as best as you can. For example, Sweet / Metallic/ Musty / Foul, etc _____

Does it stain the clothes? No / Yes ; If yes, what color? _____

12) What is your child's energy level like?

Hyperactive / Good energy / OK energy / No energy

13) When is your child's energy the best? _____

14) When is your child's energy at its worst? _____

15) Does your child suffer from? (Check all that apply)

Constipation / Diarrhea / Hemorrhoids / Gas / Bloating

16) Does your child have any pain while urinating? Yes / No

17) Does your child suffer from urinary tract infections? Yes / No

Does the urine have a strong odor? Yes / No

If yes, please describe _____

Name: _____

Section D: Skin & Nails

1) Check any skin conditions your child has now or in the past?

Eczema | Psoriasis | Warts | Skin tags | Cradle cap | Athlete's foot | Ringworm | Scabies | Impetigo | Acne | Acne rosaseae | Hives | Other

Section E: Sleep

1) What is his/her sleep like? Good | Fair | Average | Poor | Terrible

2) Does he/she sleep through the night? Yes | No |

3) Is he/she sleeping in his/her own room or with the caretaker? _____

4) In what position does he/she sleep?

_____

5) Does he/she? Sleep walk | Sleep talk | Grind teeth | Snore

6) Is bedwetting a problem for your child?

7) Does he/she suffer from nightmares on a regular basis? Yes | No |

Section F: Personality and Behavior Assessment

In Homeopathy treatment, it is helpful to know about anything that makes us unique as individuals. The following questions will help me to get to know more about your child's behavior and personality:

1) What best describes your child's growth and development? Take into account the age when learning to walk, talk, etc.

Failure to thrive | Slow to develop | Average development Developed fast |

2) Does your child have any fears? Yes / No

If yes, please list:

_____

_____

Name: _____

Section G: Your commitment to getting well

(Please answer this section as honestly as possible)

Some of you have had your complaints for a long time. For those longstanding or "chronic" complaints, a level of commitment on your part is needed in order to get well.

1) How long has your child had his/her complaint?

_____

_____

2) How long are you prepared to commit to homeopathic treatment in order to get well?

_____

_____

3) What changes in your child's diet or lifestyle are you prepared to make in order to get well (if no changes, please say no change)?

_____

_____

Name: _____

Section H: Payment policy

Unless arranged ahead of time, payment is expected on the day of your visit. We accept cash, cheque and all major credit cards. It's better to pay cash,or transfer through Zelle on (732-983-2283) as with all credit cards, there would be surcharge of 5%.

Section I: Cancellation policy

We believe in maintaining respect of time for both our patients and ourselves. The homeopathic consultation is extremely thorough and takes a significant amount of time. This specific block of time is reserved for your full, uninterrupted session.

If you cannot keep a scheduled appointment, you must notify us a **minimum of 48 hours** prior to your scheduled time, or you will be charged for the appointment. If your appointment is on Monday, please notify our office no later than noon on the previous Friday if you can't make it.

I acknowledge that I have read and understood the 48 hour cancellation policy.

_____ _____

Signed Date

Credit card details:

Card type: _____

Card number: _____

Expiry date: _____/_____/_____

Last 3 numbers on the back of the card: _____

Billing zip code: _____

Name: _____

General Consent Form for Child Under 18 Years of Age

I, _____, the undersigned parent/guardian (circle one), hereby grant, Pratibha Gupta, Homeopathic Consultant, the authority to provide homeopathic care for the following child:

Child Name: _____ Birth Date: ___/___/___

This grant of temporary authority shall begin on _____ and shall remain effective until terminated by the undersigned of client has turned 18 years of age, whichever comes first.

Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the person, the homeopath regards the mental and emotional as well as physical aspects as important. A minor aggravation or worsening of some symptoms may occur as a part of the general healing process.

Confidentiality: I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to self or to others.

Consultation: I authorize discussion of my child‘s case notes with other professional homeopaths should assistance in remedy selection and/or symptom analysis be required for my child’s best interest be served by such a consultation. In so doing, his/her/their right to privacy will be protected by withholding my name and all other identifying information.

Consent of Parent(s)/Guardian: I am 18 years of age or older and have voluntarily chosen homeopathic treatment for my child. I understand that Pratibha Gupta, is a homeopath and not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check-ups for my child. I further understand that Pratibha Gupta does not diagnose, treat, or prescribe for any particular symptom, disease, or condition. I understand that she will work on increasing my child general vitality and constitutional strength.

Signature Of Parent/Guardian: _____

Name of Parent/Guardian: _____

Email of Parent/Guardian: _____

Phone Number of Parent/Guardian: _____

Date: ___/___/___ www.VivaciousHomeopathy.com