Sam Adkins

THE HOMEOPATHIC COACH

OVERCOME HEALTH CHALLENGES NATURALLY

CHILD HEALTH HISTORY

Please complete this form and BRING IT WITH YOU to your initial consultation.
Online consults: Please save and email to sam@thehomeopathiccoach.com

PATIENT DETAILS

Child's Name: ....

DOB .... Age .... Sex ....

Parents' Names ....

Address: ....

....

Email: ....

Phones: .... H .... W .... M..............................

GP

Name: ....

Phone: ....

Address: ....

....

Learn how to use Homeopathy
with our EASY ONLINE COURSES

MAIN HEALTH ISSUE

What problem would you like treated (please describe) ....

....

....

....

....

....

List your child's current symptoms and any factors which make them better/worse

(activity/rest/foods/temperature/weather etc)

Symptom ....

Modifying factor ....

....

....

....

....

When did this problem start? (include here any events that preceded it such as,moving house, after an illness.)

....

....

....

....

Please list all conventional and complementary medical treatments you have tried so far for this issue.

Please rate them on a scale of (1 low efficacy and 5 highly efficacy)

....

....

....

....

Additional health issues

....

....

....

....

What medications/supplements/herbs is your child currently taking?

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PATIENT GENERAL HEALTH INFORMATION

Does your child have? Please rate all of the following on a 1-5 scale (1 is low severity and 5 is high severity)

Allergies/sensitivities to Drugs (eg penicillin)..

Foods..

Environmental (eg pollens or dust) ....

DIGESTIVE SYMPTOMS

Tummy Pain..

Bloating..

Indigestion ....

Diarrhoea ....

Constipation..

Wind/burping ....

Itchy bottom/nose ....

How often does your child have a bowel motion? ....

Does your child have any food cravings?..

Are there any foods which disagree with your child? ....

SLEEP PROBLEMS

Difficulty getting to sleep ....

Waking during sleep .... What time? ....

How is your child on waking?...

SYMPTOMS IN OTHER AREAS? (Please check any thing current)

☐ Head ☐ eyes ☐ ears ☐ nose ☐ teeth ☐ chest ☐ urinary tract ☐ menstrual ☐ reproductive

☐ skin ☐ skeletal

Does your child have any of the following currently or in the past (please check)

☐ Eczema ☐ asthma ☐ hayfever

BODY TEMPERATURE

Would you describe your child's body temerate as (please check)

☐ Average ☐ Warmer than normal ☐ Cooler than normal

Are your child's hands/feet usually (please check)

☐ Hot ☐ Cold ☐ Sweaty ☐ Clammy

MORE ABOUT YOUR CHILD

Fears or phobias ....

Is your child anxious? please describe: ....

....

Describe your child's usual temperament ....

....

Please outline here any emotional/behavioural problems your child may be experiencing ....

....

....

....

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YOUR CHILD'S MEDICAL HISTORY

The mother's health during pregnancy? ....

Did your child experience any birth trauma? ....

Breastfed? ☐ Yes ☐ No .... How long? ....

Any medications given to mother/child during pregnancy/labour/birth? ....

Did your child have any vaccination reactions? (Please bring your child's blue book to the consultation)

....

Recurring infections? Yes/no .... Where? ....

Approx number of courses of antibiotics taken in total? ....

PLEASE GIVE DETAILS OF ANY ADDITIONAL HEALTH ISSUES YOUR CHILD HAS HAD

(including operations, viruses, injuries)

0-5 ....

....

5-10 ....

....

10-15 ....

....

FAMILY MEDICAL HISTORY

Please list known diseases of family members (skin problems, heart disease, high blood pressure, cancer, diabetes, mental illness, other)

Mother ....

....

Father ....

....

Close family ....

....

DESIRED OUTCOME FOR YOUR TREATMENT?

....

....

....

ANYTHING ELSE YOU WANT ME TO KNOW? (Use this space to tell me things you do not want to say in front of your child)

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The Homeopathic coach | Suite 103, 91 O'Sullivan Rd, Rose Bay, NSW 2029 | Phone: +61420 800 725
sam@thehomeopathiccoach.com | www.thehomeopathiccoach.com
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