Please complete the following questions about your child's health and medical history. Please leave unanswered any question you are unsure of, or that you would rather discuss in person.

Patient's name:

Date of birth:

Address:

Post code:

Parent's Tel home:

Parent's Tel mobile:

GP's name, address and telephone number:

What you would most like help with:

Any current medication (name, strength & dosage):

When was the last course of antibiotics your child took, and what was it for?

Is your child taking any supplements or natural/alternative remedies at the moment?

Does your child have any mercury amalgam fillings (silver)?

If yes, how many?

Does your child have any allergies, intolerance's or sensitivities to any substances?

Childs Medical History:

Did the mother take the contraceptive/morning after pill before the child was conceived?

Was your child conceived naturally or was any fertility treatment needed?

Was your mother in good health and happy/relaxed when she was pregnant with you?

Did the parents use any recreational drugs?

Was the birth normal?

If not, please give details, e.g. induced, caesarean section etc:

Was the child breastfed?

If yes, for how long?

Please give brief details of all illnesses, accidents, traumas and operations at each of the following life stages. Please include the specific age at which any of the following occurred:

Birth to age Age:

Childhood illnesses and infections (measles, mumps, chickenpox, whooping cough);

Recurring illnesses (like tonsillitis, frequent flu, etc);

Serious accidents or injuries (e.g. car crash, loss of consciousness, blows to the head);

Surgical operations (e.g. tonsillectomy, dental surgery, any general anaesthetics);

Chronic or long-standing complaints (e.g. eczema, ME, arthritis);

Emotional issues;

Illnesses/treatment:

Birth to age 7yrs:
Age: Illnesses/treatment:

Age 8 to 15yrs:
Age: Illnesses/treatment:

Vaccinations – please tick all those you have received and indicated your age at the time:

Vaccination	Received?	Approximate age(s)
DPT (diphtheria, whooping cough, tetanus)		
Polio		
HIB		
MMR (mumps, measles, rubella)		
Rubella (on its own)		
Meningitis C		
BCG		
Yellow fever		
Rabies		
Anti-flu		
Tetanus (on its own)		
Hepatitis A		

Hepatitis B		
Typhoid		
Cholera		
Other:		

Have your child had a covid 19 injection?

If yes, how many and which type?

Have your child ever had an adverse reaction to a vaccination or immunisation, such as a fever, swelling, fits, a feeling of being unwell, or soreness at the injection site?

How much exercise does your child do in an average week?

Family Medical History:

Please list all chronic/long term or serious health problems that you know of for the following members of your blood relatives such as: arthritis, cancer, asthma, eczema, heart disease, high blood pressure, diabetes, depression, mental health issues, lung disease, tuberculosis, hayfever Please include fatal illnesses, year of death and age at death, if known.

Father:
Father's mother:

Father's father:

Mother:

Mother's mother:

Mother's father:

Great grandfathers:

Great grandmothers:

Aunts and Uncles:

Brothers and sisters:

Have your child ever received homeopathic treatment before?

Which, if any, other alternative/complementary therapies have you used to date?

Any other information that you think would be useful for your homeopathic practitioner to know?