ONTARIO COLLEGE OF HOMEOPATHIC MEDICINE

CHILD HISTORY

Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____ ☐ M ☐ F Weight:_____ Height: _____

Parents:		
Address:		
City:	**Province:**	**Postal Code:**
Mother's Phone:		**Father's Phone:**
Family Physician:		**Phone:**

E-mail address: _____

Would you like to be added to our mailing list to receive special offers and event notices? Yes____ No ____

How did you hear about OCHM Student Clinic?

Referral:_____ Newspaper:_____ Public Health Talk:_____Internet/Website:_____Other:_____

Child's main health concerns:

When did this problem begin? Did anything happen in the child's life during this time?

What makes the problem worse?

What time of day or night is the problem the worst?

Are there any symptoms that accompany the problem?

Please check the following conditions your child may have now:

☐ Bedwetting	☐ Eczema / rashes	☐ No Energy
☐ Breathing Problems	☐ Hard to please	☐ Sleeping Problems
☐ Colic	☐ Heart Murmur	☐ Speech Problems
☐ Constipation	☐ Hyperactivity	☐ Tantrums
☐ Convulsions	☐ Jaundice	☐ Teeth Problems
☐ Diarrhoea	☐ Learning Problems	☐ Vision Problems
☐ Digestive Problems	☐ Much crying	
☐ Ear Infections	☐ Nervousness	☐ Other _____

Please check the following childhood conditions your child may have had or is having now:

☐ Chicken Pox	☐ German Measles	☐ Whooping Cough
☐ Diphtheria	☐ Injuries/Burns	☐ Accidents
☐ Frequent Colds	☐ Measles	

☐ Operations for what: _____

☐ Hospitalisations for what: _____

Vaccinations:

☐ Chickenpox	☐ Mumps	☐ Tetanus
☐ Diphtheria	☐ Pertussis	☐ Other _____
☐ Measles	☐ Polio	

Any adverse reactions to vaccines? _____

Number of bowel movements per day: _____

332 Dupont Street
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CHILD'S BIRTH HISTORY:

Birth Weight:	**Rh Blood Problems**?
Any complications during and after delivery?	
Number of hours in labour:	
Was the delivery: ☐ Normal ☐ Premature ☐ Caesarean ☐ Forceps Aided ☐ At Home ☐ In Hospital ☐ Drug Aided ☐ Difficult	
Was this child breastfed?	If yes, for how long?
Type of formula used:	
When did the child start eating solid foods?	
What foods were introduced first?	

MOTHER'S PREGNANCY HISTORY (please circle applicable answer):

Did you have any problems conceiving?	Yes / No				
Was it a stressful pregnancy?	Yes / No				
Did you experience any of the following?:					
Anaemia:	Yes / No	Fatigue:	Yes / No	Nausea:	Yes / No
Vomiting:	Yes / No				
Did you use any of the following during pregnancy?:					
Alcohol:	Yes / No	Antibiotics:	Yes / No	Cigarettes:	Yes / No
Iron Supplements:	Yes / No	Recreational Drugs:	Yes / No	Sedatives:	Yes / No
				Sleeping Pills:	Yes / No
Did you undergo the following procedures during pregnancy?:					
X-rays:	Yes / No	Ultrasound:	Yes / No		
Were you on a special diet? If yes, why?					
How much weight did you gain during pregnancy?					
What was your emotional state when pregnant with this child?					
During the pregnancy, did you suffer any shocks, traumas, or losses?					
Did you have any food cravings or aversions during pregnancy?					

THE FOLLOWING SHOULD BE FILLED OUT BY THE CHILD IF HE/SHE IS BETWEEN 12 AND 16 YEARS OF AGE:

Do you like to be with your friends or prefer to be alone?	
Do you prefer to be with your family?	
Are you confident?	
Do you feel you are different?	
Is it easy for you to become angry?	**Are you irritable?**
Do you bite your nails?	**Do you grind your teeth?**
Any sleeping problems?	**Do you or did you ever wet the bed?**
Are you a nervous person?	
Do you feel "hyperactive"?	
Do you feel lazy?	
Do you have difficulties in school?	
Are you unhappy?	
Do you have any fears?	
Do you have any worries?	
What would you like to change about yourself?	

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FAMILY HISTORY

Please check any of the following ailments which may be present in your family history:

Alzheimer's __	Alcoholism __	Cancer __	Diabetes __	Depression __
Gonorrhoea __	Hypertension __	Heart Disease __	Hepatitis __	Mental problems __
Skin Disease __	Syphilis __	Tuberculosis __	Other:_____	

Relationship	**Age**	**If deceased, age at death**	**Cause of Death**	**Diseases**
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister (s)				
Brother (s)				

Please list the name and phone number of your family physician:

_____

Has the child been treated by a Homeopath before? _____

If yes, what is his/her name? _____