Date __________

CONFIDENTIAL CHILDREN'S HOMEOPATHIC QUESTIONNAIRE
(For Doctor and patient's parents only)

Patient's Name: __________________________ **Patient's Date of Birth:** _________
Parent's Name: __________________________ **Work Phone Number:** __________
Address: ________________________________ **Phone Number:** _______________

<u>Major Concern:</u> (Include onset of this behavior; any predisposing causes, if known)

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<u>Pregnancy:</u> Any complications, shocks, traumas or grief while carrying this child? Any prolonged morning sickness? Was birth Normal?

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<u>Family History:</u> Does this child's parents, grandparent's, etc., have any history of Tuberculosis, skin diseases, Cancer, poor diet, venereal disease?

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<u>Nursing Stage:</u> When was the child weaned? ___________________________________
When did the teeth appear? __________________; **Start talking?** ________________
Start walking? _____________________

<u>Eating:</u> Appetite: likes/dislikes, drinking habits:

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Sleeping Habits: Comment on positioning of head, dreaming and postures:

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Times of the day: Is there any times of the day when the child appears much better of worse:

Correction: Do you punish the child and in what way:

Rashes: Any history of skin eruptions in the child?

Any other specific behaviors which you have noticed which need to be told: