Linda Latta D.C.H.M., C.N.P.

Homeopathic Medicine ~ Holistic Nutrition

Child Intake Form

Date: _____ Date of Birth: _____

Patient's Name: _____ Age: _____

Mother's Name: _____Father's Name:_____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Cell: _____ Email: _____

Occupation: _____

Occasionally e-mails are sent out with new information or health seminar dates, may we include you? YES /NO?

What are your CHIEF CONCERNS in order of priority? Since when? Cause?

1. _____

2. _____

3. _____

Can you trace the origin of your child's illness to any particular circumstance, accident, illness, incident or mental upset? (e.g., shock, worry, dietary, overexertion, weather)?

_____

_____

Is your child currently taking any MEDICATIONS or SUPPLEMENTS? Please list all.

Medication	Since	Adverse Effects

Please list any major SURGERIES you have had in the past including dates:

_____ _____

_____ _____

Have you had any <u>INJURIES</u>? **When?**

_____ _____

_____ _____

What <u>VACCINATIONS</u> has your child had? Adverse reactions? YES/ NO – if so, please comment (fever etc.)

_____

Vaccination History:

Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Meningitis	Yes	No
Hep B	Yes	No

Have your child lost any weight recently? YES/NO **How much? _____**

Please check which of the following you have experienced or are suffering from <u>now</u> (N) or in the <u>past</u> (P):

__ Abortion	__ Diabetes	__ Hypertension	__ Measles	__ Rheumatic Fever	__ Venereal Warts
__ Alcoholism	__ Eczema	__ Hepatitis	__ Miscarriage	__ Sexual Abuse	__ Warts
__ Allergies	__ Epilepsy	__ Herpes	__ Mononucleosis	__ Skin Disease	__ Whooping Cough
__ Anemia	__ Emphysema	__ Influenza	__ Mumps	__ Strep Throat	__ Worms
__ Appendicitis	__ Gall Stones	__ Jaundice	__ Nosebleeds	__ Sinusitis	__ Yellow Fever
__ Asthma	__ Goiter	__ Kidney Disease	__ Ovarian Cysts	__ Stroke	__ Yeast Infections
__ Cancer	__ Gonorrhea	__ Pneumonia	__ Parasites	__ Syphilis	
__ Chicken Pox	__ Gout	__ Leukemia	__ Tonsillitis	__ Thyroid problems	Other:
__ Cold Sores	__ Hay Fever	__ Liver Disease	__ Prostatitis	__ Tuberculosis	_____
__ Depression	__ Heart Issues	__ Malaria	__ Psoriasis	__ Urticaria	_____

Have you obtained the services of a Homeopath or Naturopath for your child in the past? YES/NO

IF YES – Please list all homeopathic remedies that your child has taken OR is presently taking?

_____

Which of the following ailments, or any other major ailments, have affected your child's relatives:

Alcoholism	Allergies Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Mental Illness	
Paralysis	Pneumonia	Skin Disease	Syphilis	Tuberculosis	

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Previous pregnancies by natural mother, miscarriages or complications:_____

Mother's age at birth ____ Mother's health during pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, etc.

_____

_____

Birth History: Full Term_____Premature:_____Late:_____Weight at Birth:_____

Length of Labour:_____Complications:_____

AGE your child began: Sitting_____Crawling_____Walking_____First Words_____

FEEDING: Breast Fed?_____How long?_____Formula?_____Milk/Soy or other?_____

FOOD INTOLERANCES?_____Age began solid foods? _____

Is there any other information that I need to know? _____

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Linda Latta is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Linda Latta, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my child's consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Parent Signature:_____Date:_____

Witness:_____

Please list any other natural health practitioners that you are now seeing: (ie/Chiropractor etc.)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

FAMILY PHYSICIAN (name and tel #): _____

EMERGENCY CONTACT: _____ PHONE: _____

How did you hear about me?

Clinic Referral: ___

Flyer/Advertising: ___

Internet: ___

Friend: _____ (please print name)

Other: _____

CLIENT CONSENT

I, _____, confirm that the above information was answered to the best of my ability.

Signature _____ Date: _____

Thank you for taking the time to complete this form.
All information contained herein will remain strictly confidential.

Cancellation Policy

24hrs advanced notice is required for all missed appointments in order to wave appointment fee