

NEW PATIENT QUESTIONNAIRE (CHILD)

Please complete this form carefully and thoroughly. Your child's 'red book' will be a useful source of dates etc for their first year. All information will be kept confidential.

Child's name

Child's date of birth:

Your name

Address

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Postcode

Home telephone no.

Mobile telephone no.

email address

Referred by: Family / Friend / G.P. / Advert / Other – Please specify

General Practitioner

GP address

GP telephone no.

CONSENT AND ACCEPTANCE OF TERMS AND CONDITIONS

On behalf of my child, I understand that homeopathy is an alternative approach to health that involves me taking full responsibility for my health. I will not hold Dorothy Watt or Crossroads Homeopathy liable in any way for my health issues and understand they accept no liability.

I understand I should only withdraw medication after consultation with my GP and under their supervision. I must contact my GP or Casualty Department for medical emergencies.

I understand that a cancellation charge of the full fee will apply if I fail to give at least 24 hours notice before my appointment or for non attendance.

Accepting the above provisos I request homeopathic treatment for my child from Dorothy Watt.

Signed

Date

Describe the condition(s) about which you and your child would like to consult me:

PRESENT TREATMENT

List any current medication including vitamins, supplements etc.

List any other current treatment and complementary therapies:

MEDICAL HISTORY

List all your child's major diseases, accidents, hospitalisations, medical treatments and traumas in chronological order. Include childhood diseases and any long term prescriptions such as steroids, antibiotics etc which your child is taking / has taken. If you have any information about your child's birth or your pregnancy and labour please include that as well.

Pre-birth:

Any emotional / physical problems experienced during your pregnancy

Birth:

Details of labour, pain relief, interventions.

Birth weight**Any breast feeding?**

Describe your child as a baby eg sleep patterns, feeding, general mood etc

age

condition

treatment

Childhood illnesses:**Accidents:**

Note serious ones and those which you feel are important

Surgical procedures / major dental works:

Was anaesthesia used?

Use of drugs:

Heavy / prolonged use.

Severe viral infections:

e.g. meningitis, glandular fever etc

Shocks/traumas:

Anything which may have affected mental/emotional /physical wellbeing.

Vaccinations: List all vaccinations, with dates received, and any reactions

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Allergies: List any allergies, past and/or present with age it started / stopped.

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FAMILY MEDICAL HISTORY

List all diseases of blood relations, including cause and age of death where applicable. If possible, **please include any long-term prescriptions which you or your partner were taking before the child's birth (eg contraceptive pill, recreational drugs) and give an indication of when these were used.** Please also indicate where there may be a history of alcoholism, drug addiction, behavioural problems, birth defects, disabilities or any particular condition or problem. This information is genuinely of value and will be kept confidential.

Mother	Father
Grandmother	Grandmother
Grandfather	Grandfather
Aunts	Aunts
Uncles	Uncles
Cousins	Cousins
Brothers and Sisters	

Any other information you think might be useful (please continue overleaf if necessary):