Homeopathic Case Record
New Patient
Paediatric Intake

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KINDLY READ THIS FIRST BEFORE COMPLETING THE FORM

Children are treasured and precious. All parents aspire to give the best upbringing possible to their child, especially good health.

Homeopathic medicine is fast gaining popularity, especially in pediatric ailments because of its gentle methods of cure with no side effects.

Homeopathic medicine is helpful to children, as it increases the resistance of an individual by boosting the immune system. Thus, it helps the individual to fight against various diseases. Homeopathy treats children as a whole, rather than just their symptoms. Hence, a homeopath will observe the child in terms of overall appearance, the way he/she behaves, answers questions and his/her entire pattern of physical, emotional and mental characteristics.

Each child has his/her own imaginary world, which only he/she can explain. In a way, he/she is the act, director and producer of his/her own life. This inner fantasy world of the child is a gateway for a homeopath to enter into the child's realm. To help understand the child's innermost disturbance, it is vital to understand the child's fears, dreams, fantasies, favourite cartoons, toys, TV programmes, movies, drawings, poetries, etc.

The state of the mother during the pregnancy is one of the most important factors that helps in understanding the child. All of the physical and emotional changes experienced by a woman during the pregnancy cast a big influence on the child. During this period, the child himself has not seen the world, but he/she is feeling, perceiving or sensing it through the mother. Hence, it is essential to understand how the mother thinks, feels, perceives and senses herself in the pregnancy period and the world around her. This can be recognized by the smallest of change in nature, behavior, unusual dreams, fears, thoughts and emotions of the mother, any alternation in the desire or aversion for food substances, any particular illness during this period, etc.

The state of the father during the period of conception is also at times significant to understand the constitution of a child. In such cases, we need to enquire about the father's feelings/thoughts/sensations during the period when they were planning to have a child.

Homeopathic treatment also improved the attitude of a child towards life, optimizes his/her potential, enhances creativity and performance to the best of his/her abilities.

All this information is essential and helps select the remedy. In order to find out all about the child, I shall be asking you (child or parent or guardian) several questions. Each one of these questions has a definite meaning and significance to us. There is not a single question that is of lesser importance. Even something that you may think is not connected with the child's troubles may be the most important factor in deciding the correct homeopathic medicine. That is why you must be free, frank and spontaneous, and give detailed information on each point. Please read each question carefully, think and if necessary, consult someone close to the child and then answer completely. Do not keep anything back. Remember, whatever you tell us me will remain absolutely confidential.

All information will be kept strictly confidential.

Patient Name: _____

Date of Birth: _____ Age: _____

Name of Father: _____

Name of Mother: _____

Full Address: _____

_____

_____

Home phone Mobile – Mother Mobile – Father

_____

Email – Mother Email - Father

Referred by: _____

Has your child had homeopathic treatment before? If so, when? _____

_____

Signature of Parent/Guardian if Child is under 18

Major Complaints in Order of Importance (why your child is here)

1. _____
   Complaint Since When Origin of Cause
2. _____
   Complaint Since When Origin of Cause
3. _____
   Complaint Since When Origin of Cause
4. _____
   Complaint Since When Origin of Cause

What medication(s) is your child currently taking?

Name of Medication Dose Since Side Effects

_____

_____

_____

Past History: Circle the following conditions that your child has or had:

Abscesses	AIDS/HIV	Alcoholism	Allergies	Anemia
Anxiety Disorder	Arthritis	Asthma	Cancer	Chicken Pox
Cold Sores	Colitis	Depression	Diabetes	Eating Disorder
Eczema	Emphysema	Epilepsy	Gallstones	Goiter
Gonorrhea	Gout	Grief	Hay Fever	Headaches
Heart Disease	Hepatitis	Genital Herpes	Influenza	Kidney Disease
Leukemia	Malaria	Measles	Miscarriage	Mononucleosis
Mood Disorder	Mumps	Parasites	Pleurisy	Pneumonia
Post Partum Depression	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever
Schizophrenia	Sexual Abuse	Serious Shock	Skin Disease	Strep Throat
Sinusitis	Stroke	Sunstroke	Syphilis	Tonsillitis
Tuberculosis	Typhoid Fever	Venereal Warts	Warts	Whooping Cough
Worms	Yellow Fever			

Any other conditions?

_____

_____

Please transfer circled illnesses from page 3 and complete chart below:

Condition	Approximate Age	Duration	Whether your child recovered completely	Medicines & treatment taken	Any other particulars

What major injuries or surgeries has your child had?

_____

Type Age

_____

Type Age

_____

Type Age

_____

Type Age

VACCINATION HISTORY:

Indicate whether your child has been vaccinated for the following:

☐	Diphtheria	Age: _____	☐	Measles:	Age: _____
☐	Pertussis (whooping cough)	Age: _____	☐	Mumps:	Age: _____
☐	Tetanus	Age: _____	☐	Rubella:	Age: _____
☐	Chicken Pox	Age: _____	☐	Influenza:	Age: _____
☐	Other	Age: _____			

Did your child experience any adverse reactions from any of the vaccinations?

_____

_____

_____

FAMILY HEALTH HISTORY (to be completed by parent(s):

Please circle which of the following ailments have affected your family:

Anemia	Alcoholism	Allergies	Arthritis	Asthma
Cancer	COPD	Diabetes	Eczema	Epilepsy
Gallbladder	Gonorrhea	Heart Disease	Hypertension	Inflammatory Bowel Disease
Irritable Bowel Syndrome	Kidney Disease	Liver Disease	Mental Illness	Osteoporosis
Pneumonia	Syphilis	Tuberculosis	Ulcers	

	Current Age	Age at Death Cause	Major Ailments
Mother			
Father			
Sister(s)			
Brother(s)			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunt(s)/Uncle(s)			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt(s)/Uncle(s)			

INFORMATION ABOUT CHILD'S SIBLINGS:

Sibling's Name	Alive/ Deceased	Age	Gender	Disease(s) Suffered

DEVELOPMENTAL HISTORY:

At what age did your child start:

Holding head up: _____ Begin teething: _____ Sitting: _____

Speaking: _____ Standing: _____ Walking: _____

Urine control: _____

Is there anything else I should know about your child's growth and development?

_____

_____

_____

ALLERGIES:

Does your child have any allergies? If yes, please describe

_____

_____

_____

SLEEP:

In what position does your child sleep? _____

When sleeping, does your child:

Snore:	_____	Dribble saliva:	_____	Keep eyes open:	_____
Grind your teeth:	_____	Sweat:	_____	Keep mouth open:	_____
Walk:	_____	Talk:	_____	Moan:	_____
Weep:	_____	Wake up with a jerk:	_____	Uncover any parts during sleep:	_____

Does your child have nightmares? _____

About what? _____

How often? _____

What is the child's behavior while experiencing a nightmare and upon waking up from a nightmare?

_____

_____

Circle the types of dreams your child has:

Animals Cats — Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death — Whose? Dead bodies Dead persons Part of body Suicide
Being hungry Being thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work
Vomiting Passing stool Urinating Blood — Bleeding Excrement/soiling	Romantic Sexual pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure / Exams Unsuccessful efforts? For what? Missing train Being unprepared
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom? - For what?	If any other, specify in the space below:	
Of people Children Parties Feasts Marriages	Of events Remote Recent Future Prophetic	Physical exertion Mental exertion Fatigue Coloured Multi-coloured		

SKIN:

Does your child have any skin complaints? If so, describe:

_____

_____

_____

OTHER COMPLAINTS:

Does your child get headaches? If yes, please describe.

_____

MOTHER'S HISTORY DURING PREGNANCY (to be completed by Mother):

1. Was the pregnancy planned or unplanned?

_____

_____

2. Describe the circumstances around the period of conception? (Stressful if any)

_____

_____

3. What changes did you observe within you?

_____

_____

4. Anything unusual or particular phenomena you observed only during pregnancy that you think where not a part of your routine nature and that occurred with the pregnancy?

_____

_____

5. Any incident during pregnancy that had a deep impact on you? Describe your feelings, thoughts of any sensation associated with it?

_____

_____

6. What were your dreams during pregnancy (Also mention dreams around the time of conception, if any)? Did you have any unusual, recurrent dreams that had a deep impact on you?

_____

_____

7. Did you have any fear or nightmares during this period? Please describe:

_____

_____

8. Was there any change in your interests and hobbies during your pregnancy?

_____

_____

9. What were the changes in the likes/dislikes of any particular food during pregnancy?

_____

_____

DELIVERY HISTORY:

1. Was the delivery full term/early/delayed?

_____

_____

2. Was it a Caesarian section/forceps/vacuum delivery? Were any other procedures done?

_____

_____

FEMALE:

Age of first menses: _____ Regular or irregular: _____

No. of days of flow: _____ Circle flow: heavy / medium / light

Are stains difficult to wash: _____ Are there clots? _____ If so, describe:

_____

Do your child suffer in any way before, during or after menses? _____ Please describe:

_____

_____

Method of birth control? Since when: _____

Any miscarriages/abortions? _____

MALE:

Any problems with genitals? Urination? _____

MIND SECTION:

1. How does the main complaint and associated complaints affect the child?

   _____

   _____

2. What are his/her fears (existing and/or imaginary)?

   _____

   _____

3. Is there any incident which has had a deep impact on him/her? Please describe in detail.

_____

_____

4. What are the stories/fairytales that he/she likes to read/listen to?

_____

_____

5. What are his/her imaginations/fantasies? Please describe in detail.

_____

_____

6. What are his/her interests and hobbies?

_____

_____

7. Describe the specific toys, games, specific TV serials, cartoon/movie characters that the child lies.

_____

_____

8. How is her/she at sports and other activities?

_____

_____

9. Describe the drawing and colour that he/she likes.

_____

_____

10. What are other activities that your child likes to do?

_____

_____

11. Describe all of the qualities of your child, which makes him/her different from other children, which are unique to him/her.

_____

_____

12. What does he/she want to become when he/she grows up and why? What are his/her ambitions?

_____

_____

13. Whom does he/she idealize and why? What is it about him/her that he/she admires the most?

_____

_____

14. How is his/her behavior with parents, teachers, friends and relatives? What are the qualities the he/she admires in them?

_____

_____

15. How is his/her behavior in school and what is his/her teacher's opinion about the child?

_____

_____

16. What kind of questions does he/she ask of parents, relatives and teachers?

_____

_____

17. What are his/her views about the city, state, country and world?

_____

_____

18. What makes your child cry or laugh?

_____

_____

19. What makes your child very angry and irritable?

_____

_____

20. What does the child do when he/she is alone?

_____

_____

21. What are your child's first five wishes?

(i)

(ii)

(iii)

(iv)

(v)

Please ask your child to draw something that comes to his/her mind this moment or their favourite drawing:

Which of the following qualities does your child have? Check (✓) once and twice (✓✓) if more intense.

Obstinacy	_____
Temper tantrums	_____
Aggression	_____
Hyperactivity	_____
Destructiveness	_____
Courage	_____
Possessiveness	_____
Sibling jealousy	_____
Unusual desires (for what)	_____
Stealing	_____
Telling lies	_____
Unusual fears	_____
Shyness	_____
Unusual attachments (to whom)	_____
Nail biting	_____
Thumb sucking	_____
Religious	_____
Sensitive/emotional	_____

Thank you for taking the time to complete this form.