Nicky Lee homoeopath & nutritionist

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Please take time to complete this form and bring it with you to your child's first consultation. Date _____

Name _____ Date of Birth _____

Address _____

Email _____ Home tel _____ Mobile _____

Name & Tel number of GP _____

Calibration of Health - on a scale of 1 to 10 (1 being poor and 10 being excellent) how do you think they feel:

Emotionally _____ Physically _____ Energetically _____

Presenting Complaint [the condition/s you would like help with] _____

_____

_____

_____

Has your child ever had any of the following? If yes, please give details and dates if possible:

Head injuries, headaches, migraines, etc _____

Ear, nose, throat problems (glue ear, tonsillitis) _____

Allergies / sensitivities (food, hay fever, hives, prickly heat) _____

Skin (cradle cap, eczema, warts, verrucas, molluscum) _____

Breathing (asthma, bronchitis, croup) _____

Digestive problems (colic, wind, eating disorders) _____

Bowels (diarrhea, constipation) - do they pass a stool daily? _____ If not how often? _____

Are their stools ever loose, hard, contain mucous or undigested food? _____

Reproductive system (thrush, menstrual problems) _____

Urinary (cystitis, bedwetting, involuntary) _____

Musculoskeletal (sprains, strains) _____

Accidents or stays in hospital _____

Present and past medication - drugs / antibiotics / steroids / inhalers / antihistamine etc _____

_____

_____

Have they had any previous homoeopathic or nutritional treatment, please give details? _____

_____

Vaccinations [please include ages/dates and any reactions] _____

_____

_____

Do they have any silver amalgam (grey) fillings, how many? _____

Do/have they ever suffered from bleeding gums, mouth ulcers? _____

Have they ever suffered from Athlete's foot, Thrush, Cystitis, Fungal nails, Bloatedness, Fuzzy memory?

(please circle any/all)

How much juice and fizzy drinks consumed per day?_____ Amount of water drunk per day?_____

How much time spent using a computer / watching TV?_____ Hours per week using a mobile phone ?_____

Do you use a microwave, how often? _____

How long have you lived at your present address and are you happy there? _____

Do they sleep well?_____ Do they wake up during the night? Any specific time/s?_____

Do they wake refreshed? _____ Do they ever have nightmares? _____

Do they or have they ever suffered from anxiety, depression, panic attacks, phobias? Please give details____

_____

_____

Have they had any major shocks or traumas in their life? Please give details _____

_____

_____

Details of your pregnancy (general attitude to being pregnant, traumas, emotional upsets)? _____

_____

_____

Details of their birth (natural delivery, c-section, epidural)? _____

_____

Breastfed – how long? Any formula given, if so which one/s? _____

Childhood development & illnesses _____

_____

_____

Family Medical history

This information is very important.

Please list any serious illnesses, long-term health issues in your family and cause of death if appropriate.

Mother's side	**Father's side**
Mother _____	Father _____
Mother's mother _____	Father's mother _____
Mother's father _____	Father's father _____
Mother's sisters _____	Father's sisters _____
Mother's brothers _____	Father's brothers _____

Sisters _____

Brothers _____

Cousins _____

Diet and Digestion

Do you prepare all meals from fresh ingredients?_____

Do you use organic products?_____ Do they crave any particular food or taste?_____

Please give an example of an average day:

Breakfast

Lunch

Dinner

Snacks