

San Diego Homeopathy  
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**HOMEOPATHIC QUESTIONNAIRE FOR INFANTS AND CHILDREN**

<b>First name:</b>	<b>Last name:</b>
<b>Mother's name:</b>	<b>Father's name:</b>
<b>Date of birth: / /</b>	<b>Today's date:</b>
<b>Address:</b>	<b>Sex (Circle):    Male    Female</b>
<b>City:</b>	<b>Height:                      Weight:</b>
<b>ZIP:</b>	
<b>Home telephone:</b>	<b>Work Telephone:</b>
<b>Cell phone/pager:</b>	<b>Website:</b>
<b>Emergency contact: (Name, relationship, Address, Tel)</b>	
<b>Email address:</b>	<b>Parent's occupation(s):</b>
<b>Religion:</b>	<b>Contact details for primary doctor:</b>
<b>MARITAL STATUS OF PRIMARY CARETAKER: (Circle)</b>	
<b>Single, Married, Gay, Divorced, Separated, Widowed, Domestic partnership</b>	

How did you find out about us? \_\_\_\_\_

Thank you for taking the time to fill out this questionnaire.  
 It designed to help us develop a deeper understanding about your complaint, as well as  
 assess your child's overall health.

Some of the questions may appear completely unrelated  
 to the reason you are seeking help.

However in homeopathy, we look at not only the primary complaint,  
 but also take into account many factors of your child's growth, development, family  
 background and personality when deciding on a homeopathic remedy.  
 We help children of all ages. Depending on the age of your child, there may be some  
 questions which are not applicable to your child. Simply leave out those questions.

We look forward to helping you.

**Please type or write neatly.**  
**You may fax, hand deliver, mail or email this questionnaire**  
**to the clinic, or bring it along with you to your visit.**

**THIS REPORT WILL BE TREATED AS STRICTLY CONFIDENTIAL**



## Section B: MEDICAL HISTORY

List any medication/ vitamins/ herbs or supplements your child is currently taking:

DRUG	DOSAGE	INDICATION

*Don't forget to bring along any relevant medical records you have available.*

List medicines your child has taken frequently in the past or over an extended period of time.

DRUG	DOSAGE	INDICATION

List any surgeries your child has had:

DATE	SURGICAL PROCEDURE	REASON

What childhood illness/injuries has your child had?

AGE	ILLNESS/ INJURY	REACTION TO ILLNESS e.g. frequency, reoccurrences, severe, hospitalized, mild
AGE	CHILDHOOD ILLNESSES	REACTION TO ILLNESS e.g reoccurrences, frequency, severe, mild hospitalization, etc

Has your child had any of the following **illnesses**? Check all that apply:

Mumps<sup>1</sup> Measles<sup>1</sup> Chicken-pox<sup>1</sup> Polio<sup>1</sup> Glandular fever<sup>1</sup> Mononucleosis<sup>1</sup> Pneumonia<sup>1</sup>  
 Eczema<sup>1</sup> Asthma<sup>1</sup> Tuberculosis<sup>1</sup> Cancer<sup>1</sup> Gonorrhoea<sup>1</sup>

Name: \_\_\_\_\_

Which **vaccinations** has your child had? Check all that apply:

Small pox  Polio  Mumps  Measles  Chicken pox  Tetanus  Hepatitis  Flu  Other

Have you had any vaccinations in the last year? Yes  No  If Yes, describe:

Has your child ever had any reactions to vaccination? Yes  No  If Yes, describe

Does your child have any **allergies**? If yes, please list:

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### **Section C: FAMILY HISTORY**

Please fill in the details of your child's family's medical history. If your child is adopted and you do not know his/her family's history please indicate so and leave out this section. Please fill in this section as best as you can. Many of you will not know all the details, and that is fine too.

	<b>Age</b>	<b>History of illness, current state of health</b>	<b>Age of death</b>	<b>Cause of death</b>
<b>Father</b>				
<b>Mother</b>				
<b>Brothers</b>				
<b>Sisters</b>				
<b>Paternal Grandmother</b>				
<b>Paternal Grandfather</b>				
<b>Maternal Grandmother</b>				
<b>Maternal Grandfather</b>				

Are there any illnesses that run in your family? \_\_\_\_\_

Is there any family history of: Please check: Tuberculosis  Cancer  Gonorrhoea  Scabies

Name: \_\_\_\_\_

**Section D: DIET & LIFESTYLE**

Is your child currently breastfeeding? Yes No

If your child is eating solid foods, please complete the following:

This is to find out what your child typically eats during the day. Please answer this section as honestly as possible.

**BREAKFAST:**

Time: \_\_\_\_\_

Eat what: \_\_\_\_\_

Snack: \_\_\_\_\_

**LUNCH:**

Time: \_\_\_\_\_

Eat what: \_\_\_\_\_

Snack: \_\_\_\_\_

**DINNER:**

Time: \_\_\_\_\_

Eat what: \_\_\_\_\_

Before bed: \_\_\_\_\_

Do you wake up at night to eat/ drink? Yes<sup>1</sup> No<sup>1</sup> Please describe: \_\_\_\_\_

Any foods that your child strongly **desires**? \_\_\_\_\_

Any foods that your child strongly **dislikes**? \_\_\_\_\_

Any foods that make your child ill? \_\_\_\_\_

If yes, what symptoms do you experience? \_\_\_\_\_

Which of the following tastes do you desire the most? Check all that apply:

Sweet<sup>1</sup> Salty<sup>1</sup> Sour<sup>1</sup> Spicy<sup>1</sup> Pungent<sup>1</sup> Pickles<sup>1</sup> Bitter<sup>1</sup>

**Smoking:**

Are there any smoker's living in the home? Yes No

## **Section E: General symptoms**

Please **CHECK** the information that applies to you:

- 1) Is your child? Thirsty  Thirstless  Some where in between
- 2) What does your child like to drink? \_\_\_\_\_
- 3) Does he/she? Sip drinks slowly  Gulp drinks down  Neither
- 4) Does he/she prefer drinks that are? ice cold  hot drinks  room temperature
- 5) Is his/her appetite? Ravenous  Average  Small  Increased  Decreased
- 6) Is his/her body temperature? Too hot  Too cold   
Can't stand heat /cold  Not significant
- 7) What weather is he/she best in? \_\_\_\_\_
- 8) Is there any weather that aggravates him/her? \_\_\_\_\_
- 9) Is his/her perspiration? Extreme  Profuse  Average  Slight  Not at all
- 10) Where does he/she perspire from? \_\_\_\_\_
- 11) Please describe the odor of his/her perspiration as best as you can? E.g. sweet, metallic, musty, foul, etc \_\_\_\_\_
- 12) Does it stain his/her clothes? No  Yes  If yes, what color? \_\_\_\_\_
- 13) What is his/her energy level like? Hyperactive  Good energy  OK energy  No energy
- 14) When is his/her energy best? \_\_\_\_\_
- 15) When is his/her energy at its worst? \_\_\_\_\_
- 16) Does he/she suffer from? (Check all that apply) Constipation  Diarrhea  Hemorrhoids   
Gas  Bloating
- 17) Does he/she have any pain on urinating? Yes  No
- 18) Does he/she suffer from urinary tract infections? Yes  No
- 19) Does his/her urine have a strong odor? Yes  No  If yes, please describe \_\_\_\_\_

## **Section F: Skin & Nails**

- 1) Check any skin conditions your child has now or in the past?  
Eczema  Psoriasis  Warts  Skin tags  Cradle cap  Athlete's foot  Ringworm   
Scabies  Impetigo  Acne  Acne rosacea  Hives  Other   
Describe these skin complaint(s) in detail, noting whether he/she suffers from it now or previously and any treatment(s) used?  
\_\_\_\_\_  
\_\_\_\_\_
- 2) Describe his/her fingernails: Cracked  Peel  White spots  Fungus  Discolored  Ridged
- 3) Describe his/her toe nails: Cracked  Peel  White spots  Fungus  Discolored  Ridged
- 4) Does he/she? Bite his/her nails  Peel his/her nails

## **Section G: Sleep**

- 1) What is his/her sleep like? Good  Fair  Average  Poor  Terrible
- 2) Does he/she sleep through the night? Yes  No
- 3) Is he/she sleeping in his/her own room or with the caretaker? \_\_\_\_\_
- 4) In what position does he/she sleep? \_\_\_\_\_

Name: \_\_\_\_\_

- 5) Does he/she? Sleep walk<sup>1</sup>      Sleep talk<sup>1</sup>      Grind teeth<sup>1</sup>      Snore<sup>1</sup>
- 6) Is bedwetting a problem for your child?
- 7) Does he/she suffer from nightmares on a regular basis? Yes <sup>1</sup> No<sup>1</sup>

**Section H: Personality and behavior assessment:**

In Homeopathy treatment, it is helpful to know about anything that makes us unique as individuals. The following questions will help me to get to know more about your child's behavior and personality:

- 1) What best describes your child's growth and development? Take into account age learning to walk, talk, etc. Failure to thrive<sup>1</sup> Slow to develop<sup>1</sup> Average development<sup>1</sup> Developed fast<sup>1</sup>
- 2) Does your child have any fears? Yes No  
If yes, please list: \_\_\_\_\_
- 3) Is masturbating an issue for your child? Yes<sup>1</sup> No<sup>1</sup>
- 4) Are there any behaviors, habits or personality traits that stand out that distinguish your child from other children? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 5) Is masturbation an issue for your child? Yes <sup>1</sup> No<sup>1</sup>

**Section I:**

**a) Mother's pregnancy**

- 1) Did you have any difficulty conceiving? Yes<sup>1</sup> No<sup>1</sup>
- 2) How many times have you been pregnant? \_\_\_\_\_
- 3) Have you had any miscarriages? Yes <sup>1</sup> No<sup>1</sup> If yes, how many? \_\_\_\_\_
- 4) Have you had any abortions? Yes <sup>1</sup> No<sup>1</sup> If yes, how many? \_\_\_\_\_
- 5) Do you have any other children? Yes<sup>1</sup> No<sup>1</sup> If Yes, list ages: \_\_\_\_\_
- 6) Describe any problems you had during pregnancy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

7) Describe your emotional state during pregnancy, including any stresses that you had?

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8) Check all that apply to describe your labor?    Vaginal delivery<sup>1</sup>    Caesarian section<sup>1</sup>  
Forceps delivery<sup>1</sup>    Used suction<sup>1</sup>    Episiotomy<sup>1</sup>    Epidural<sup>1</sup>    Analgesics<sup>1</sup>    Fetal  
distress<sup>1</sup>    Water birth<sup>1</sup>    Home birth<sup>1</sup>    Had midwife<sup>1</sup>

9) Describe any complications during labor? \_\_\_\_\_

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10) How long were you in labor for? \_\_\_\_\_

11) What did you use for pain relief during labor? \_\_\_\_\_

12) Did you breastfeed? Yes<sup>1</sup>    No<sup>1</sup>    If Yes, how long for: \_\_\_\_\_

**Section J: Your commitment to getting well.**

(Please answer this section as honestly as possible)

Some of you have had your complaints for a long time. For those longstanding or "chronic" complaints, a level of commitment on your part is needed in order to get well.

1) How long has your child had his/her complaint? \_\_\_\_\_

2) How long are you prepared to commit to homeopathic treatment in order to get well? \_\_\_\_\_

3) What changes in your child's diet or lifestyle are you prepared to make in order to get well (if no changes, please say no change)? \_\_\_\_\_

**Section K: Payment policy:**

Payment is expected on the day of the appointment. We accept most credit cards except American Express.

**Section L: Cancellation policy**

We believe in maintaining both respect of time for both our patients and ourselves. The homeopathic consultation is extremely thorough and takes a significant amount of time. This specific block of time is reserved for your full, uninterrupted session.

Please allow a minimum of 24 hours notice for this cancellation. Any cancellations made less than 24 hours will be charged a \$40 cancellation fee. I acknowledge that I have read and understood the 24 hour cancellation policy.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

