Homeopathic Health Services, Aaron Means MA– Homeopathic Practitioner
1516 W Lake St, Ste 224, Minneapolis, MN 55408
480-262-8511; homeopathichealthservices.com; homeopathichealth@gmail.com

CHILD REGISTRATION FORM-HOMEOPATHY

Name:_______________________________________ Birthdate_________
Contact Address:____
City, Zip:____________________________Sex: M F Weight___Height____
Home Phone:______________________
Mother's Name__________________Work/Cell Phone:__________________
Father's Name:__________________Work/Cell Phone:__________________

Main Email Address____________________________________

Siblings (Include ages):____
Pediatrician (Include name and address): ___________________________
____
Referred by____

Current School (Include Grade):____________________________________
Contact in case of emergency_____________________________________

Birth History (Include birth weight, problems during pregnancy or afterbirth
____
____
Give the following information for the last times your child has been hospitalized starting with the most recent including type of illness, month and year hospitalized, name of hospital, city and state.
#1:____
#2:____
#3:____
Allergies:____
Medications(Type, Dosage, Frequency):______________________________
____
Medicinal Herbs, Vitamins, Teas:___________________________________
Does your child use: ˙Coffee: Amount____ ˙Cigarettes:______________
˙Alcohol: Amount________ ˙Other drugs: Amount_______________

YEAR	Tests	YEAR	Immunizations
_____	˙ MMR	______	˙Smallpox
_____	˙ DPT	______	˙Tetanus
_____	˙ TB test	______	˙Polio
_____	˙Typhoid	______	˙ Hepatitis
_____	˙Other x-rays	______	˙Other

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CHECK yes only if your child has *recently* been bothered by any of these problems.

Y

__ frequent or severe headaches
__ back pains
__neck lumps or swelling
__ loss of balance
__dizzy spells
__blackouts/fainting
__ wear glasses
__blurry vision
__ eyesight worsening
__see double
__see halos or lights
__ eye pains or itching
__ watering eyes
__ earaches
__ hearing difficulties
__ running ears
__ noises in ears
__ dental problems
__sore or bleeding gums
__sore tongue
__congested nose
__running nose
__sneezing spells
__head colds
__nosebleeds
__ sore throat
__ difficulty swallowing
__ hoarse voice
__ wheezing or gasping
__ frequent coughing
__ cough up phlegm
__cough up blood
__ chest colds
__rapid or skipped heart beats
__ chest pains
__shortness of breath
__swollen feet or ankles
__armpits or groin swelling
__difficulty sleeping
__ motion sickness
__ excessive sweating

Y

__recurring indigestion
__ frequent belching
__ nausea
__ vomiting
__ pain in abdomen
__ bloated abdomen
__constipation
__loose bowels
__black stools
__grey or whitish stools
__ pain in rectum
__itching rectum
__ blood with stools
__ frequent urination
__ involuntary urination
__ burning on urination
__ black or bloody urine
__ weak urine stream
__diff. starting urine
__ constant urge to urinate
__hopeless outlook
__difficulty relaxing
__worry a lot
__scary dreams or thoughts
__ feeling of desperation
__ shy or sensitive
__dislike criticism
__ angered easily
__ annoyed by little things
__family problems
__ problems at work/school
__ sexual difficulties
__change of sexual energy
__ considered suicide
__ loss or gain in weight
__ loss of appetite
__ always hungry
__ fatigue or weariness
__fever or chills
__night sweats
__ hot flashes
__warm/colder than others

Y

__aching muscles or joints
__swollen joints
__back or shoulder pains
__weakness in arms or legs
__painful feet
__trembling
__numbness
__leg cramps
__skin problems
__scalp problems
__ itching or burning skin
__bruise easily
__ nervousness or anxiety
__nervous with strangers
__nail biting
__diff. making decisions
__lack of concentration
__loss of memory
__ lonely or depressed
__ frequent crying

Men/Boy only

__burning or discharge
__swelling on testicles
__painful testicles

Women/Girls only

__ a missed period
__ menstrual problems
__bleeding between periods
__heavy bleeding
__bearing down feeling
__vaginal discharge
__genital irritation
__pain on intercourse
__swelling in breasts
__painful breasts
_____#of pregnancies
_____#of births
_____#of miscarriages
_____#of caesareans
_____# of abortions

Main Reason for Visit Today/Comments or Special Problems:

____
____

What are you most sensitive to (eg. noise, odors, light, pain)?__________
____
____
Describe an ideal day in terms of weather and temperature: ___________
____
What are your fears?____
____
____
____
Do you have any hobbies?____
____
(Women only) What symptoms do you experience premenstrually?______
____
____
Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: ____
____
____
____
____
____
____
How is your energy? Is there any particular time of day when it is lower or higher?____
____
What environment do you fell most comfort in? (ie desert, mountains, ocean, city)____
____
What do you most like to eat or crave?_________________________________
____
____
What is your favorite color?____
What foods do you most dislike?_____________________________________
____
How is your thirst?____
What temperature do you like fluids?_________________________________

Are there any foods that you are sensitive to or allergic to?____________
____

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Family History: Place an (X) in the appropriate columns for any illnesses that your child or your relatives have had.

ILLNESS	Self	Father	Mother	Brothers	Sisters	Child#1	Child #2	Child #3	Grandparents
ALLERGIES									
ANEMIA									
ARTHRITIS/GOUT									
ASTHMA									
BLEEDING PROBS									
CANCER									
EPILEPSY									
DIABETES									
ALCOHOL/DRUGS									
ECZEMA									
EMPHYSEMA									
HEART TROUBLE									
HEPATITIS									
HIGH BLOOD PRESS									
FREQ INFECTIONS									
KIDNEY PROBS									
MENTAL ILLNESS									
MIGRAINES									
ABNORMAL PERIODS									
PSORIASIS									
PNEUMONIA									
POLIO									
PROSTATE PROBLEMS									
RHEUMATIC FEVER									
STOMACH PROBS									
STROKE									
THYROID PROBLEMS									
TUBERCULOSIS									
ULCERS									
VENEREAL DISEASE									
WEIGHT PROBLEMS									