Avalon Homeopathy @ Avalon Laser Health
Tara Jensen, DSHM, BA 709-753-0155

Child Homeopathic Consultation Form

Patient's Name:____ Date of Birth: ____Y____M____D

Mother's Name:___________________________________ Father's Name:___________________________

Address: ____
Street City Postal Code

Telephone: Home ______________________ Work (M) ________________ Work (F) ____________

Telephone: Other (M) _____________________ Other (F) ___________________

E-mail address: ____

Referred By: ____________________________ Present MD & Phone No. ____________________________

Major Complains in order of importance:

Complaint	Since	Cause

Medications your child is currently taking:

Complaint	Since	Cause

Which of the following conditions has your child had?

Abscesses Allergies Anemia Asthma Chicken Pox Cold Sores Colic
Ear Infections Eczema Frequent Colds Influenza Measles Mononucleosis Mumps
Parasites Pneumonia Rheumatic Fever Rubella Scarlet Fever Skin Ailments
Strep Throat Sinusitis Sun Stroke Tonsillitis Thrush Travel Sickness
Tuberculosis Typhoid Fever Warts Whooping Cough Worms

Any Other Major Conditions?

____

Are there any of the preceding conditions after which your child has not been totally well again? Which ones?

____

Any Major Operations/Injuries?

Operation/Injuries	When	Complications

Vaccination History: Any adverse effects from any of these vaccinations?

Measles Yes No
Mumps Yes No

Rubella/German Measles Yes No
Chicken Pox Yes No

Whooping Cough Yes No
Meningitis Yes No
Hep B Yes No

Which of the following ailments, or any other major ailments, have affected your child's relatives?

Alcoholism Allergies Arthritis Asthama Cancer Depression
Diabetes Epilepsy Gonorrhea Gout Heart Disease Mental Illness
Paralysis Pneumonia Skin Disease Syphilis Tuberculosis

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts			
Maternal Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts			
Paternal Uncles			

Previous pregnancies by natural mother, marriages or miscarriages? ______________________________

____

Mother's age at child birth: ________________ Mother's health during Pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drugs, cigarette consumption

____

Birth History: Full Term _____ Premature: _____ Late:_____ Weight at Birth: _____

Length of Labour: ________ Complications: ____

Age your child began: Sitting _______ Crawling _______ Walking _________ First words _________

Feeding: Breast Fed? ___ How long? _____ Formula? ______ Milk/Soy or other? ______

Food intolerances? ___________________ Age began solid foods? ______________________

Is there any other information that I need to know? ____

____

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Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 year of age, a parent or guardian must sign). I, the undersigned, understand that Tara Jensen is a homeopathic practitioner of classical homeopathy and is not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Tara Jensen, I am exercising my right to choose an alternative method of treatment through which I address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my child's consultations may be used to homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Parent Signature: ______________________________ Date: ___________________________