

JACKIE CLASON, CCH.

PEDIATRIC INTAKE FORM

Today's Date _____

Child's Name _____
Parent's Name _____
Home Phone _____ Cell _____ E-Mail _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Age _____ Sex (circle) M F
Referred by _____
Names of other health care practitioners _____
Name of nearest friend or relative who may be called in an emergency:
_____ Relationship _____
Phone number _____ Address _____

Instructions: Put a check in the boxes applicable to you/ write in your answer.

1) Reason for today's visit:

2) Illnesses/Injuries: Have you had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Poisoning of any kind | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Recurring headaches | <input type="checkbox"/> Recurring backache | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver/gallbladder disease | | <input type="checkbox"/> Frequent colds or illnesses |

List any other illnesses or injuries: _____

3) Surgery/hospitalizations:

- Tonsillectomy _____
 Appendectomy _____

List any other operations or periods of hospitalization: _____

4) Immunizations: Have you had any of the following immunizations?

- Polio
 Diphtheria/pertussis/tetanus (DPT)
 Measles, mumps, rubella (MMR)
 Smallpox
 Tetanus booster (last ten years)
 Hepatitis

List any others:

5) Allergies: Are you allergic to any foods:

drugs or medications: _____ Other substances: _____

6) Medications: List any medications you are currently taking: _____

7) Habits/Environment: Do you:

- Awaken feeling unrested?
- Have trouble sleeping?
- Have problems with constipation?
- Have trouble relaxing or enjoying your spare time?
- Have problems at school?
- Do you exercise?
How much and how often? _____

8) Diet: Do you:

- | | |
|---|---|
| <input type="checkbox"/> Feel your diet is inadequate? | <input type="checkbox"/> Regularly eat fried food? |
| <input type="checkbox"/> Eat at irregular intervals? | <input type="checkbox"/> Use sugar on your food or in drinks? |
| <input type="checkbox"/> Eat in a hurried atmosphere? | <input type="checkbox"/> Use sugar in cooking? |
| <input type="checkbox"/> Eat quickly and forget to chew? | <input type="checkbox"/> Eat foods with artificial coloring, flavoring, or preservatives? |
| <input type="checkbox"/> Eat between meals? | <input type="checkbox"/> List all vitamins or dietary supplements you are taking:

_____ |
| <input type="checkbox"/> Drink with meals? | |
| <input type="checkbox"/> Eat out more than once a week? | |
| <input type="checkbox"/> Follow a special or restricted diet? | |
| <input type="checkbox"/> Avoid certain foods? | |
| <input type="checkbox"/> Regularly salt your food? | |

9) Family History:

Which member of your family or near relatives had/have:

Diabetes _____	Cancer _____
Hives or hay fever _____	Depression _____
Arthritis or gout _____	Stroke _____
Thyroid problems _____	Epilepsy _____
Bleeding problems _____	Neurological disease _____
Weight problems _____	Anxiety _____
High blood pressure _____	Asthma _____
Tuberculosis _____	Venereal disease _____
Heart problems _____	Alcoholism _____
Kidney problems _____	Drug addiction _____

10) Any other pertinent information:

GENERAL CONSENT FORM

Name _____

Child's Name (If applicable) _____ Date of Birth _____

Jackie Clason, CCH. has been in practice since 1991. She is registered with the North American Society of Homeopaths and is certified with the Council for Homeopathic Certification. She has agreed to abide by the Code of Ethics of each of these organizations.

Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the whole person, the homeopath regards the mental and emotional as well as physical aspects as important. A minor aggravation or worsening of some symptoms may occur as a part of the healing process.

CONFIDENTIALITY

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to him or herself or to others.

CONSULTATION

I authorize discussion of my case notes with other professional homeopaths should assistance in remedy selection and/or symptom analysis be required (for myself or my child) or my best interest be served by such a consultation. In so doing, my right to privacy will be protected by withholding my name and all other identifying information.

CONSENT

I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself/ for my child. I understand that Jackie Clason is a homeopath and not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check-up for myself/for my child. I further understand that Jackie Clason does not diagnose, treat or prescribe for any particular symptoms, disease or condition. I understand that she will work on increasing my/my child's general vitality and constitutional strength.

Signature: _____ Date: _____