Jack Gagliardi, Homeopath
Homeopathic Medicine

Jack Gagliardi, Homeopath
18 Filmic Lane, Toronto, ON, M4M 3R1
416-832-3448 | www.homeopathyheals.com

Pediatric Pre-consultation Questionnaire
Homeopathic Client Information

*Please note that all information provided is kept in the strictest confidence according to the regulations of Homeopath – patient confidentiality

PATIENT'S LAST NAME:_____

PATIENT'S FIRST NAME:_____

MOTHER'S NAME: _____ **FATHER'S NAME**: _____

ADDRESS:_____

CITY:_____ **PROV**: _____ **POSTAL CODE**:_____

HOME PHONE:_____ **WORK PHONE**:_____

EMAIL: _____

Child's Date of Birth (MM/DD/YYYY):_____

Family Doctor: _____

Address: _____

City: _____ **Prov**: _____ **Postal Code**: _____

Phone: _____ **Fax**: _____

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE:

Complaint	Since	Causes

WHAT MEDICATIONS IS YOUR CHILD CURRENTLY TAKING?

Medication	For What Condition?	Since	Any Adverse Effects?

WHAT OTHER TREATMENTS OR THERAPIES IS YOUR CHILD CURRENTLY FOLLOWING?

Therapy	Since	Results

HAS YOUR CHILD HAD ANY HEALTH PROBLEMS AFTER WHICH HE/SHE HAS NEVER BEEN TOTALLY WELL SINCE? WHICH ONES?

_____

MAJOR OPERATIONS?

Operation	Date	Complications

MEDICAL HISTORY

DOES YOUR CHILD HAVE ANY ALLERGIES? IF SO, PLEASE LIST THEM:

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

Please circle any that apply:

Abscesses, Anemia, Arthritis, Asthma, Chicken Pox, Cold Sores, Colic, Eczema, Frequent Colds, Influenza, Measles, Mononucleosis, Mumps, Parasites, Pneumonia, Psoriasis, Rheumatic Fever, Rubella, Scarlet Fever, Sexual Abuse, Skin Diseases, Sinusitis, Strep Throat, Sunstroke, Tonsillitis, Tuberculosis, Typhoid Fever, Warts, Whooping Cough, Worms, Yellow Fever

Other: _____

CAN YOU TRACE THE ORIGIN OF ANY OF YOUR CHILD'S PRESENT CONDITIONS TO ANY PARTICULAR CIRCUMSTANCE? (e.g. accident, illness, grief, mental upset etc.)

_____

ANY SERIOUS SHOCK, GRIEF, DISAPPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

_____

FAMILY HEALTH HISTORY (Please list age if alive, age at death, ailments, cause of death)

MOTHER: _____

FATHER: _____

BROTHERS: _____

SISTERS: _____

CHILDREN: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

MATERNAL AUNTS/UNCLES: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

PATERNAL AUNTS/UNCLES: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING VACCINATIONS?

MEASLES □ MUMPS □ RUBELLA □ PERTUSSIS □ CHICKEN POX □ FLU □
OTHER: _____

ANY ADVERSE REACTIONS? _____

PREVIOUS PREGANANCIES BY NATURAL MOTHER, MISCARRIAGES OR COMPLICATIONS?

_____

MOTHER'S HEALTH DURING PREGANANCY? LIST ANY BLEEDING, NAUSEA, ILLNESS, PHYSICAL OR EMOTIONAL TRAUMA, HYPERTENSION, DIABETES, MEDICATIONS, ALCOHOL, DRUG, CIGARETTE CONSUMPTION ETC. _____

_____

MOTHER'S AGE AT CHILD BIRTH: _____ **BIRTH HISTORY**: FULL TERM __ PREMATURE __ LATE: __

WEIGHT OF CHILD 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? _____

ANY OTHER INFORMATION?

_____

PERSONALITY PROFILE

Many times your child's health can be influenced by their mental/emotional state. As an aid to help determine the best homeopathic remedy for your child, please circle any of the following characteristics that describe your child best. Please bring the profile with you to the first appointment along with the pre-consultation intake form.

Animated
Playful
Sociable
Convincing
Refreshing
Spirited
Promoter
Spontaneous
Optimistic
Funny
Delightful
Cheerful
Inspiring
Demonstrative
Mixes easily
Talker
Lively
Cute
Popular
Bouncy

Self-reliant
Positive
Sure
Outspoken
Forceful
Daring
Confident
Independent
Decisive
Mover
Tenacious
Leader
Chief
Productive
Bold

Sensitive
Planner
Scheduled
Orderly
Faithful
Detailed
Cultured
Idealistic
Deep
Musical
Thoughtful
Loyal
Caretaker
Perfectionist
Behaved

Controlled
Reserved
Satisfied
Patient
Obliging
Friendly
Diplomatic
Consistent
Inoffensive
Dry humour
Mediator
Tolerant
Listener
Contented
Permissive
Balanced

Brassy
Undisciplined
Repetitious
Forgetful
Interrupts
Unpredictable
Haphazard
Permissive
Angered easily
Naive
Wants credit
Talkative
Disorganized
Inconsistent
Show-off
Loud
Scatterbrained
Restless
Changeable
Adventurous
Persuasive
Strong-willed
Competitive
Resourceful

Bossy
Unsympathetic
Resistant
Frank
Impatient
Unaffectionate
Headstrong
Proud
Argumentative
Nervy
Workaholic
Tactless
Domineering
Intolerant
Manipulative
Stubborn
Short-tempered
Rash
Crafty
Analytical
Persistent
Self-sacrificing
Considerate
Respectful

Bashful
Unforgiving
Resentful
Fussy
Insecure
Unpopular
Hard to please
Pessimistic
Alienated
Negative attitude
Withdrawn
Too sensitive
Depressed
Introvert
Moody
Skeptical
Loner
Suspicious
Revengeful
Critical
Adaptable
Peaceful
Submissive

Blank
Unenthusiastic
Reluctant
Fearful
Indecisive
Uninvolved
Hesitant
Plain
Aimless
Nonchalant
Worrier
Timid
Doubtful
Indifferent
Mumbles
Slow
Lazy
Sluggish
Reluctant
Compromising

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PLEASE READ THE FOLLOWING CAREFULLY

*If under 18 years old, a parent or guardian must sign.

I,_____ the undersigned, understand that Jack Gagliardi is not a *medical doctor*, but instead a Homeopath. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Jack Gagliardi, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate homeopathic treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its entirety.

FEE SCHEDULE: (Payment Options: INTERAC, VISA, MasterCard, Cheque, Cash)

As homeopathy is not covered by existing government medical insurance plans, I agree to pay all fees incurred as presented in the current rate schedule below. (Rates are subject to change)

CHRONIC CASES:

INITIAL VISIT: $160 **INITIAL VISIT: CHILDREN UNDER 12 YEARS - $140**

OPTIONAL: Additional $50 for Live Blood Analysis (A Live Blood Analysis may be performed with your Initial Visit based on a recommendation by your Homeopath if he believes your case – depending on your medical condition - will benefit from the test **OR** at the request of the patient curious to see the state of their blood for informational purposes).

FOLLOW-UP VISITS: $60

ACUTE CASES: $25

* Colds, flus, minor coughs, sore throats, healing after injuries (broken bones, bruising, pre and post-surgical treatment)

Remedy Refills without visit: (If applicable):** $14.61/ bottle

OTHER SERVICES:

• LIVE BLOOD CELL/NUTRITIONAL ANALYSIS/COUNSELLING $70

***Fees do not include HST ** Some remedy prices may vary**

***Some extended health care plans cover homeopathy**

Patient Name (Please Print): _____

Patient Signature: _____**Date:** _____

Jack Gagliardi, HD Doctor of Homeopathic Medicine

Preparing for Your Homeopathic Appointment which includes Live Blood Cell Analysis

Please remember to fast (no food) for at least 4 hours before every appointment (unless directed otherwise by your Homeopath). You may drink water and are encouraged to drink at least 4 glasses of water leading up to your appointment.

Fasting will ensure an accurate Live Blood Cell Analysis.

Remember to bring a snack to eat after your blood is taken, as you may be hungry during the appointment.

If you have any questions, please do not hesitate to call (416-832-3448) or email me (jack@homeopathyheals.com).

YOUR CHILD'S FIRST HOMEOPATHIC APPOINTMENT
- REPORTING SYMPTOMS -

Determining the proper homeopathic remedy for your child involves investigating and evaluating all the subjective and objective symptoms that he/she is experiencing in the context of their physical symptoms, individual life circumstances and environment. In order to develop an accurate picture of their circumstances, and to make our time spent in consultation most effective, I request that you think about and keep in mind the following requests for information, as in-depth and accurately as possible. If you have any questions, feel free to contact me.

1. Think about, in detail, the onset of your child's symptoms. Any related mental, emotional or physical symptoms and/or any external condition(s) that may have contributed to their state of being at that time?

2. Think about all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these aliments. Were there any extensive therapies employed in the healing of these conditions? Did they have any reactions or long-term side effects to any such therapies?

3. Think about the symptom they are experiencing in terms of location in the body. Does this symptom shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptom? How it feels/looks/smells/tastes? Anything that makes the symptom unique, striking or unusual? If pain is involved, think about the pain they endure ex. a dull ache vs. a sharp stabbing pain, a constant or periodic pain etc. Think about the onset of their pain; slow vs. sudden? How intense is the pain?

4. Make note of when your symptoms feel better or worse: time of day/ when they are hot or cold/hot or cold compresses/months/seasons/before or after eating/ sleep/moving resting certain positions/when occupied/ specific mental/emotional states. Experiment with heat or cold, warm rooms or fresh cool air, warm or cool bathing. Do you notice any difference in the symptom?

5. Is your child affected in any way by different kinds of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by the seashore.

6. Urination (if of concern): Colour/ odour/ sediment/ quantity/ frequency/ urgency.

7. Stool (if of concern): Number of stools per day/ colour/ odour/ hard/ dry/ large/ pasty/ bloody/ frothy/ slimy/ thin/ watery/ slender/ flat/ difficult or incomplete/ urging without stool.

8. Perspiration: Profuse/ scanty/ odour.

9. Body Temperature: Hot vs. cold body type/ hot or cold hands or feet/ hot flashes.

10. Sleep: Do they wake up at night? When? Why? How do they feel in the morning on rising? What position do they sleep-side/back/front? Are parts of the body covered or exposed with sleep? Do they have recurring dreams during sleep? Are there any prominent themes to their dreams? Night terrors?

11. How do they deal with change in their life? Do they need a great deal of structure in their life?

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