

## 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.)**

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**ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.?**

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**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?**

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

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**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?**

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## 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	Self-reliant	Sensitive	Controlled
Playful	Positive	Planner	Reserved
Sociable	Sure	Scheduled	Satisfied
Convincing	Outspoken	Orderly	Patient
Refreshing	Forceful	Faithful	Obliging
Spirited	Daring	Detailed	Friendly
Promoter	Confident	Cultured	Diplomatic
Spontaneous	Independent	Idealistic	Consistent
Optimistic	Decisive	Deep	Inoffensive
Funny	Mover	Musical	Dry humour
Delightful	Tenacious	Thoughtful	Mediator
Cheerful	Leader	Loyal	Tolerant
Inspiring	Chief	Caretaker	Listener
Demonstrative	Productive	Perfectionist	Contented
Mixes easily	Bold	Behaved	Permissive
Talker			Balanced
Lively			
Cute			
Popular			
Bouncy			
Brassy	Bossy	Bashful	Blank
Undisciplined	Unsympathetic	Unforgiving	Unenthusiastic
Repetitious	Resistant	Resentful	Reluctant
Forgetful	Frank	Fussy	Fearful
Interrupts	Impatient	Insecure	Indecisive
Unpredictable	Unaffectionate	Unpopular	Uninvolved
Haphazard	Headstrong	Hard to please	Hesitant
Permissive	Proud	Pessimistic	Plain
Angered easily	Argumentative	Alienated	Aimless
Naive	Nervy	Negative attitude	Nonchalant
Wants credit	Workaholic	Withdrawn	Worrier
Talkative	Tactless	Too sensitive	Timid
Disorganized	Domineering	Depressed	Doubtful
Inconsistent	Intolerant	Introvert	Indifferent
Show-off	Manipulative	Moody	Mumbles
Loud	Stubborn	Skeptical	Slow
Scatterbrained	Short-tempered	Loner	Lazy
Restless	Rash	Suspicious	Sluggish
Changeable	Crafty	Revengeful	Reluctant
Adventurous	Analytical	Critical	Compromising
Persuasive	Persistent	Adaptable	
Strong-willed	Self-sacrificing	Peaceful	
Competitive	Considerate	Submissive	
Resourceful	Respectful		

**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: \$210**

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

**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-\$60 DEPENDING ON THE CASE**

\* 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:** \_\_\_\_\_

## 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](mailto: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 ailments. 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?

**Jack Gagliardi, Homeopath**  
18 Filmic Lane, Toronto, ON, M4M 3R1  
416-832-3448 | [www.homeopathyheals.com](http://www.homeopathyheals.com)