Miran Farah HOM, DCHM, MBA, MSc

Pediatric Homeopathic Consultation Form

Patient's Name:_____ Date of Birth: D_____ M_____ Y_____

Mother's Name:_____ Father's Name:_____

Address:_____
Street City

Telephone: Home:_____ Work(M.)_____ Work(F.)_____

Telephone: Mobile(M.)_____ Mobile(F.)_____

E-mail address:_____

Referred By:_____ Present M.D. and Phone no.:_____

Major complaints in order of importance:

Complaint	Since	Causes

Medications or Supplements that your child is currently taking?

Medication	Since	Adverse Effects

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	Covid	Cradle Cap		

Any Other Major Conditions?_____

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

Which ones?_____

Vaccination History:

BCG (Tuberculosis)	Yes	No
Hep B	Yes	No
DPPT	Yes	No
Polio	Yes	No
Pertussis (Whooping Cough)	Yes	No
Tetanus	Yes	No
Hib	Yes	No
MMR	Yes	No
Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Meningitis	Yes	No
Hep A	Yes	No
Tetanus	Yes	No
Haemophilus	Yes	No
Pneumococcal	Yes	No
Rota Virus	Yes	No
Typhoid	Yes	No
HPV (Cervarex)	Yes	No
HPV (Gardasil)	Yes	No
Influenza	Yes	No
Yellow Fever	Yes	No
Covid	Yes	No
Yellow Fever	Yes	No

Any Adverse Effects from any of these Vaccinations?:

_____

_____

Other:_____

Any Major Operations/Injuries?

Operation/Injury	When	Complications

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

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

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

Pregnancy of Mother and Delivery History

Mother's Health during Pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, antibiotics, vaccinations, etc. --

___

_____

Conception: previous miscarriages? planned baby? eldest child? IVF? emotional trauma?

_____

Delivery? Natural, c-section, anesthesia, epidural, induced, Rhesus injection

_____

Mother's age at child birth:_____

Birth History: Full Term_____ **Premature:**_____ **Late:**_____

Birth: weight:_____ **height/length:**_____

Length of Labour:_____ **Complications:**_____

Position of Baby:_____ **Condition of Placenta**_____

At what age did your child begin to: Sit_____ **Crawl**_____ **Walk**_____ **Say 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?

_____

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Miran Farah is a homeopathic practitioner of classical homeopathy and 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 Miran Farah, I am exercising my right to choose an alternative method of treatment through which to address my total health. As The Homeopathy Healer does not accept any 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 for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Miran Farah and/or The Homeopathy Healer which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Parent Signature:_____ Date:_____

Witness:_____