STANDARDIZED
HOMOEOPATHIC CLINIC

Medical History for Homoeopathic Treatment of Children

Directions for a written submission

Introduction

1. For finding out a correct homoeopathic remedy for your child, lot of information with regard to the (i) Complaints…..(a) main as well as (b) subsidiary….(ii) the person of the patient is required.
2. Incomplete information will make correct choice difficult. You are, therefore, requested to supply all the information without keeping back anything as irrelevant or of little importance. The information you supply in the note forms the basis of further enquiry designed to assist you in the further delineation of the problem. Full co-operation therefore is requested. All information supplied is, of course, strictly confidential.
3. Since the enquiry can be time-consuming process and a lot of information is being, collected we require to record it systematically and, at times, we may find it necessary to administer to you further tests in which you are called upon to write out further.
4. We are sure you shall be fully co-operating with us in rendering you the best possible service.

Preliminary Information

Please supply the following information about your Child as standard routine: Name in full, Address, Date of birth, Sex, Religion/ Community/ Sect, Vegetarian/ Non-vegetarian/ Eggs, Habits: Tea, coffee, chocolate etc

Description of the current family set-up, full details pertaining to all the members, their ages, location, work they are doing and your relationship with responsibilities with them. Include in the list those who have died, stating the age of death, the year and the cause of the same. State if the parents have married within the family (i.e. Consanguineous marriage)

The Childs's daily routine from getting up in the morning to retiring at night. Include in his/ her dietary schedule furnishing full details in respect of the quantities consumed. State time spent for recreation and studies.

Chief Complaint

Describe fully what bothers the child most. Each trouble should be detailed as under:

1. Full description of the trouble right from the time of onset. Its subsequent development and spread and response to treatments taken. This should give full idea of**:**
    i. Area affected Location, Extension, Direction of spread, the march of events.
    ii. Sensation experienced in the area of trouble.
    iii. Conditions that have brought on the trouble: examine the circumstances that obtained just before or at the time of onset paying attention to physical as well as emotional factors.
    iv. Conditions that increase the trouble or those afford relief.
    v. Other troubles experienced at the same time along with the main trouble for example….perspiration/ nausea/ vomiting/ gas/ with pains.

Other Complaints

Describe here all other troubles the child might be having or have in the past experienced. Each should be described fully as suggested above for the Chief Complaint.

Personal Data

Give a full account of the following:

1. Physical description of the child.
2. Emotional nature: Anger, fears, attachments, shyness etc. Mention if you have noted any change in child's Behaviour/ Nature recently.
3. Intellectual attainments: School performance, Extracurricular activities, hobbies, etc
4. Give a clear-cut picture of the child's relationships with the family members, friends and teachers (School/ Tuition). Discuss the difficulties experienced by the child in any of these and effects on the child. Financial or interpersonal strains in the family if any (present as well as past).
5. Reactions to surroundings:
    a. Food: desire and aversions including desire for chalk, earth, etc., foods that do not suit, etc.
    b. General Environment: weather, temperature, bath, recreations, clothes, covering, favourite colours (if any) etc.
    c. Sleep and Dreams.
6. Growth and Development of the child.
    a) Type of delivery & birth date. Any problems soon after birth.
    b) Mother's health & emotional state during pregnancy and after delivery. Breast feeding difficulties if any.
    c) Milestones: State the age at which the child started teething, sitting, walking, talking, etc. Any complaints at that time. Give details of toilet training.

Previous Illness

Give a resume of the illnesses the child has had and to what extent these have any bearing on present troubles.

Family History

Data concerning the parents, brothers and sisters. State details concerning the health of grandparents & other blood relatives on both sides.

General Comments

Include here any items, which have not been included above.

Enclosures

1. Medical reports and opinions of Physicians / Paediatrician.
2. Copies of reports of investigation done.
3. X- ray plates, ECG, MRI, CT scan etc.

Please write this form on a separate sheet and mail us at: **drjaniclinic@gmail.com** or post us at:

Standardized Homoeopathic Clinic

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(The clinic is at a walking distance of 400m from Borivali West Metro Station)