Medical History For Homeopathic Treatment of Children

Introduction

- For finding out a correct homeopathic Remedy for your child, lot of information with regard to the (I) Complaints- (a) Main as well as (b) subsidiary-and (ii) the person of the patient is required.

- Incomplete information will make correct choice difficult. You are, therefore, requested to supply all information without keeping back anything as irrelevant or of little importance. The information you supply in the note forms the basis of inquiry 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**.

- Since the inquiry can be a time consuming process and a lot of information is being collected we require to record it systematically and, To facilitate this, we have evolved a special procedure in which the preliminary study is carried out by a physician specially assigned to this job and when your Case Record is ready, we examine it to find out if it is sufficient for instituting treatment. Sometimes more time is required for further detailed processing of information and a study of the child's case. If so, we give you a further suitable appointment for finalizing the line of treatment.

- 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 as standard routine:

Name in full:
_____

Address: _____

Phone No: Home: _____ Work_____ Cell: _____

Date Of Birth: _____Sex: _____ Religion:
_____

Vegetarian/Non-Vegetarian/Eggs: _____Habits: (Milk, chocolate Etc._____

What Grade attending if in school: _____

Description of current family set-up, full details pertaining to all members, their ages, location, work they are doing and Child's relationship with them. Include in your list those who have died, stating the age of death, the year and the cause of the same.

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

Chief Complaint

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

Full description of the trouble right from the time of onset. It's subsequent development and spread and response to treatments taken. This should give full idea of:

Area affected: Location, extension, direction of spread, and the march of events.

Sensation experienced in the area of trouble.

Conditions that have brought on the trouble; examine the circumstance that obtained just before or at the time of onset, paying attention to physical as well as emotional factors.

Condition that increase the trouble or those that afford relief.

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 has experienced in the past. Each should be described fully as suggested above for the "chief complaint".

Personal Data

Give a full account of the following:

(i) Physical description of the child:

(ii) Emotional nature: anger, fears, attachments, shyness etc. Mention if you have noted any changes in the child's behavior/nature recently.

(iii) Intellectual attainments: School performance, extracurricular activities, hobbies etc.

Give a clear-cut picture of the child's relationships with the family members, friends and teachers. Discuss the difficulties experienced by the child in any of these and effects of the child.

Financial or interpersonal strains in the family if any (present as well a past.)

Previous Illness

Give a resume of the various 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 and others.

General Comments

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

Enclosures

1. Referral note from your physician (if you have been referred) and old medical records.
2. Copies of reports of Investigations done.
3. X-ray plates, Sonography, CT scan, etc, if any.