ERIN BELLIS
DMHS REGISTERED HOMEOPATH

RIGHT FIT
300 Maitland Drive, Belleville, Ontario, K8N 4Z5
613-848-8253 erinbellis.com

Child Homeopathic Consultation Form

Patient's Name: ______________________ Date of Birth: D _______ M_______ Y_______

Mother's Name: ______________________ Father's Name: ______________________

Address: ____
Street *City* *Postal Code*

Telephone # Home _______________ Work _______________ Other _______________

E-mail Address: ____

Referred By: _______________ Present Doctor and Phone #: ______________________

Major Complaint in Order of Importance For You:

Complaint	*Since*	*Causes*

Medications that your child is currently taking?

Medications	*Since*	*Causes*

Which of the following conditions has your child had?

Allergies	Anemia	Chicken Pox	Cold Sores	Colic	Ear Infections
Eczema	Frequent Colds	Influenza	Measles	Mononucleosis	Mumps
Parasites	Pneumonia	Rheumatic Fevers		Rubella	Scarlet Fever
Skin Aliments	Strep Throat	Sinusitis	Sun Stroke	Tonsillitis	Thrush
Travel Sickness	Tuberculosis	Typhoid Fever	Warts	Whooping Cough	Worms

Any other major conditions?

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

Vaccination History:

Adverse Effects from any of these vaccinations?

Vaccination	Yes	No	Adverse Effects
Measles	Yes	No	
Mumps	Yes	No	
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	
Whooping Cough	Yes	No	
Meningitis	Yes	No	
Hep B	Yes	No	
Tetanus	Yes	No	
Haemophilus	Yes	No	
Pneumococcal	Yes	No	
Meningitis	Yes	No	
DPPT	Yes	No	

Mother's age at child birth: ____________________

Mother's health during pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, etc.

Birth History: Full Term ______________ Premature ______________ Late ______________

Weight at Birth: ____________________ Length of Labour: ____________________

Complications: ____

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 of solid foods? ____________

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 Erin Bellis is a homeopathic practitioner 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 Erin Bellis, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential.

Patient Signature: _________________________________ Date: _________________________________

Witness: ____ Date: _________________________________