



**Confidential**  
**PERSONAL DETAILS FORM**

**Please complete this section in blocked capitals**

Name of Child: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone no: \_\_\_\_\_

Date, Age & Place of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_

Height & Weight: \_\_\_\_\_

No of Siblings: \_\_\_\_\_

School (if app): \_\_\_\_\_

Doctor's Name & Address: \_\_\_\_\_

**Past Medical History**

During the child's pregnancy and birth did any of the following occur (please tick as applicable)?

Shock/fright	Accident	Grief	Medications
Premature birth	Induced birth	Caesarean birth	Assisted delivery
Other (please give details)			

Please indicate the timing of the child's first milestones (please tick):

1 <sup>st</sup> Tooth (usually around 8 months)	Early	On time	Delayed
Walking (usually around 1 year)	Early	On time	Delayed
Talking (usually around 1 year)	Early	On time	Delayed



## **Mental Disposition/Personality**

Describe the child's general nature & disposition (using about 10 words) and their adaptability and reaction situations (e.g. new people, changes to routine, starting school):

Are they (delete as applicable)?

Introvert/Extrovert  
Sociable/Prefer own company  
Very Active/Less active  
Stubborn/Amiable  
Patient/Impatient  
Tidy/Untidy

Do they (delete as applicable)?

Cry easily                      Yes/No  
Get angry easily              Yes/No  
Talk a lot                        Yes/No  
Get frightened easily        Yes/No

## **Presenting Complaint (s)**

For each one please provide brief details of the complaint and:

Medical diagnosis (if known)  
Past & present treatment (including Homoeopathy)  
Duration of problem

In preparation for the consultation please also consider the following questions:

What do you think causes it?  
What affects it, makes it better or worse?  
What other symptoms appear unrelated but occur at the same time?

1.

2.

3.

4.

Please describe below any additional comments, ailments, complaints you wish to discuss:

### **Other Current Medication**

Please detail any other medication currently being taken (including vitamins)

### **Allergies**

Please detail any allergies: (e.g. wheat, pollen, dairy)

### **Fears**

Please detail any fears: (e.g. animals, darkness, death, thunderstorms)

### **Sleep**

In what position does the child usually sleep?

How long does the child usually sleep at night?

Does the child wake during the night Yes/No

If yes, how often and how do they get back to sleep?

### **Thermal Reaction**

How would you describe the child's body temperature on the scale below

(Hot +++ e.g never wear a coat Cold +++ e.g need to wear hat, scarf & gloves

Cold +++      Cold ++      Cold +      Hot +      Hot++      Hot +++

Ordinarily, does the child like fresh air? Yes/No

**Perspiration – please give details of your perspiration:** (e.g body parts, odour, staining night/day

**Food Preferences/Aversions**

Please put the following in the order of the child’s preference beginning with 1 as the most desired (ignore nutritional value or side effects. Write what is really liked/disliked)

- 1.        Sweet        Sour        Salt/salty        Bitter        Savoury
- 2.        Chicken    Egg        Red Meat        Fish

What is the Child’s favourite food(s)?

What Food(s) if any don’t they eat as they disagree with them?

Do they like green leafy vegetable?	Yes	No	Doesn’t like them
Do they like fat on meat?	Yes	No	Doesn’t like them
Do they like milk,cream, icecream?	Yes	No	Doesn’t like them
Do they like spicy foods?	Yes	No	Doesn’t like them
What temperature do they prefer their food	Hot	Warm	Cold        Not bothered

**Thirst**

Please indicate the child’s usual drinking preferences (i.e. during the day and evening)(delete as applicable):

- Hot/Cold                      Long/Short                      Gulps/Sips                      Frequent/Seldom

Which would you consider the child to be?                      Thirsty/Thirstless