



Gentle Wellness

Homeopathy & BioEnergetics with Sandra

CHILD New Patient Intake Form

Personal Information

First and Last Name

Street Address

City

Province

Postal Code

Home Phone

Cell Phone

Email

Date of Birth

Age

Sex

Family Doctor _____

Address

City

Province

Postal Code

Phone

Referred by

Name: _____



Major medical complaints (In order of importance)

- | | | | |
|----|-------|-------|-------|
| 1. | _____ | Since | Cause |
| 2. | _____ | Since | Cause |
| 3. | _____ | Since | Cause |
| 4. | _____ | Since | Cause |

What medications are you currently taking?

Medication	Since	Adverse effects/Drug allergies
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What supplements are you currently taking?

Supplement	How much?	How often?
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Are You Currently Under the Care of a Physician(s)?

Physician	Condition?	Treatment(s)?
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What major INJURIES or SURGERIES have you had, if any?

Type:

Location:

Age:

Pregnancy:

Mother's age at child's 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: _____

Age your child began:

Sitting _____ Crawling _____ Walking _____

First Words _____

Feeding: Breast Fed/ Formula? _____ Age began solid foods. _____

Favorite foods? _____

Food Intolerances/allergies?



Check any symptoms that You have experienced:

(in past 6-12 months)

- Abdominal cramping
- Anaphylactic shock
- Arthritic type symptoms
- Canker sores
- Celiac's disease
- Constipation
- Depression
- Diarrhea or loose stools
- Difficulty concentrating
- Emotional upset
- Eczema
- Fatigue or sudden drops of energy after meals
- Gas or bloating
- Heartburn or indigestion
- Hives (Urticaria)
- Irritable Bowel syndrome (IBS)
- Irritability
- Itching – skin or rectal
- Migraine headaches
- Nausea
- Nocturnal enuresis
- Red rash around mouth, reddening or swelling of skin
- Rhinitis
- Runny nose
- Stiffness of joints
- Stomach ache
- Swelling of lips and face
- Swelling of the joints
- Vomiting
- Wheezing

Check any conditions that the child or parent(s) has had.

✓ Child

X Parent

- | | |
|---|--|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Measles |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Anxiety /Mood disorder | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Sun stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Goitre | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Yellow fever |
| <input type="checkbox"/> High Blood pressure | |
| <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Loss of Hearing | |
| <input type="checkbox"/> Genital herpes | |
| <input type="checkbox"/> Kidney/Bladder Disease | |
| <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Malaria | |



If yes to any of the previous, please explain: (we will go in depth in the appt)

Four horizontal lines for writing an explanation.

If experiencing any known allergies or intolerances

Which of the following trigger (or cause) the symptoms? Please check all that apply.

- Grass
- Hay
- Mold & Mildew
- Basements
- Leaves
- Cats
- Latex (rubber)
- Dogs
- Horses
- Other animals
- Alcoholic Beverages
- Cosmetics
- Aerosol sprays
- Other: _____
- Perfumes
- Insecticides
- Odors
- Drafts
- House dust
- Smoke
- Pollution
- Exercise
- Nervousness
- Cold Air
- Humidity
- Weather Changes

When are your symptoms worse?

- Year Round
- January
- May
- September
- February
- June
- October
- March
- July
- November
- April
- August
- December

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

Do you live in a: House Apt / Duplex Condo / Town House

Do you live In the city In the suburbs Rural areas

Of Pets? Indoor /Outdoor None Cats Dogs Birds Other

Are there any tobacco smokers in your house? Yes No

Is your bedroom in the basement? Yes No



Consent

I, _____ the undersigned, understand that Sandra O'Grady HOM, R.BIE is a Registered Homeopath and Bioenergetic (BIE) practitioner and **not** a licensed medical doctor.

- As such, I acknowledge that I am here on my own behalf and it is my right and responsibility, at any time throughout my care with Sandra O'Grady, to seek medical counsel and diagnosis, if so desired from a licensed medical doctor, for any present and/or future condition(s).
- I acknowledge that Sandra O'Grady does not diagnose or give direction on any current medications or diagnosis treatment plan from my licensed medical doctor.
- I reserve the right to terminate homeopathic and BIE treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy or BIE, that addresses my health in its entirety.
- I consent that after assessment, answering of questions, and discussion of homeopathic treatment options, to my satisfaction, I will voluntarily follow recommended treatment advice. I understand I can withdraw my consent at any time.
- I acknowledge that I understand the risks, limitations, conditions of use, and instructions for use of the select electronic communication Services such as email, text, videoconferencing (Skype, Zoom, FaceTime) and phone.
- I acknowledge and understand that despite recommendations that encryption software can be used as a security mechanism for electronic communications, it is possible that communications with Sandra O'Grady may not be encrypted. Despite this, I agree to communicate with the Homeopath understanding of the risk.
- In regards to BIE solely, I acknowledge that the GSR-120 unit is not intended to be used to diagnose, cure, prognosticate, treatment or prescribing of remedies for the treatment of disease or any act which will constitute the practice of medicine in this country in which a medical license is required.
- The GSR-120 unit is used to direct energy directly onto various acupuncture points on the body to help create homeostasis.
- Homeopathy is not covered by existing government medical insurance plans; therefore, I agree to pay all fees incurred as presented in the current rate schedule.

Patient's Signature:

Date:

If under 18 years of age, a parent or guardian must sign on your behalf.

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.