Los Angeles School of Homeopathy **Clinic In-take form** (Child)

There is a 5 day Cancelation policy

Personal Health Questionnaire

All information will remain strictly confidential. Homeopathy helps balance the whole person on a physical, emotional and mental level. Please be as open and precise as you can. If your child is old enough have, him/her fill out the questionnaire or help them through it. For babies do the best you can and use your intuition, you know your child best.

Thank you for your trust and patience. Please print clearly

Date:______________

Name:____

DOB: M/D/Y______________**Age:**___________**Place of Birth:**________________________

Address:____

____

Phone: H(__)____________________________**E-mail:** ________________________

Mother's name:____

Cell Phone: (__)__________________________**W**(__)______________________

Father's Name: ____

Cell Phone: (__)__________________________**W**(__)______________________

Grade in School:______________________________

Pediatrician:__________________**Phone:** (__)______________________________

Height:_______________________**Weight:**__________________________________

Gender Identity:_______________**Assigned at Birth:**

Preferred Pronouns:

Surgery:____

Left/Right handed:____

Siblings:______________________________**Pets:**_____________________________

Referred by: ____

Present/Current Complaint:____

Pain, Where?

History & Past Treatment & Old Injuries:

Vaccinations

	Birth	1 M	2 M	4 M	6 M	12 M	15 M	19-23 M	2-3 Y	4-6 Y	7-10 Y	11 12 Y	13 18 Y
Vitamin K (At birth)													
Silver Nitrate drops (At birth)													
Hepatitis B (At birth on going series)													
Rotavirus (2, 4, or 6 months)													
Diphtheria, Tetanus, Pertussis DTAP (2,4,6 Months, 11, 13 Years)													
Pneumococcal (PCV) (2,4,6 months)													
Polio (IPV) (2,6, Months & 6-18 Month range)													
Influenza (usually yearly)													
Measles, Mumps, Rubella MMR (12-15 Months, 4-6 Years)													
Haemophilus influenza type b Hib (2,4,6 months)													
Varicella (chickenpox) (12-15 months & 4-6 years)													
Hepatitis A (12-18 months, ongoing, series)													
Meningococcal MCV4 (3-6 years, 11 years)													
Human Papillomavirus HPV (3 doses- 11-13 Years)													

Reactions to Vaccines: ____

____

What Specific Events Have Impacted or Changed Your Life: ____________________

____

Family History Please list all ailments: (e.g. Cancer, TB, Asthma, Heart disease)

____

____

____

Personal History Circle where appropriate. Put * if you have this today

Accidents
Addictions
ADD/ADHD
Alcoholism
Allergies
Anemia
Angina
Anorexia
Anxiety
Asthma
Bi-Polar
Boils
Bulimia
Candida
Chronic fatigue
Convulsions
Depression

Diabetes 1 (Diet)
Diabetes 2 (Insulin)
Drug overdose
Drug problem
Dyslexia
Endometriosis
Epilepsy
Excessive eating
Excessive fears
Flashes (hot/cold)
Food poisoning
Fungus
Gall bladder
Hay fever
Head injuries
Headaches
Heart disease

Hepatitis
Herpes
High/Low blood pressure
HIV/AIDS
Infections
Insomnia
Jaundice
Kidney dysfunction
Liver dysfunction
Low Libido
Manic depression
Meningitis
Mental disorder
Mono
Nervous
Nightmares

Night sweats
Nose bleeds
Numbness
Panic attacks
Paranoia
Paralysis
Physical abuse
Pneumonia
Polio
Rectal problems
Ringing in ears
Sexual abuse
Skin problems
Tingling
Ulcers
Verbal abuse
Vertigo
Warts

Medication Circle where appropriate put an * if you are on them today

Anti-biotic	Heart	Radiation
Anti-inflammatory	Herbs	Relaxants
Anti-histamines	Laxatives	Sleeping pills
Antidepressant	Lithium	Street Drugs
Aspirin/Tylenol	Oral Contraceptives	Supplements
Chemotherapy	Thyroid	Vitamins
Cortisone	Over The Counter	

Other______________________________

Duration________________ How often________________

What age did your child walk: ________________

What age did your child talk: ________________

What age did the fontanels close? ________________

Mother Only

How many Pregnancies?__________ Number of births? __________

Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs? __________

Specify________________

Abnormal bleeding during pregnancy? ________________

Miscarriage:________________

C-Section:________________

Complications during Pregnancy? ________________

Which Pregnancy? ________________

Complications during Labor? ________________

Which Labor? ________________

How much alcohol do you drink?________________

Do you take medication? ________________

What were your emotions at time of conception?________________

What were your emotions during the pregnancy?________________

Father Only

Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs?

Specify________________

What were your emotions at time of conception?________________

What were your emotions during the pregnancy?________________

Did you have any complications during your wife's pregnancy? ________________

How much alcohol do you drink? ________________

Do you take medication? ________________

EMOTIONS To the best of your ability help your child fill this page out, with infants go with your instinct. Indicate with numbers: 1 being mildest -1 2 3 4 5- 5 being strongest If it does not apply then leave blank

Affectionate
Ambitious
Angry
Anxious
Assertive
Bossy
Cautious
Closed
Confidence
Courageous
Critical
Death
Depressed
Discontented
Disorganized
Distrust
Dogmatic
Dullness
Easily Hurt
Excitable
Fanatical
Fastidious
Fearful
Flirtatious
Forceful
Forgetful
Generous

Grief
Guilty
Hold in Feelings
Hurried
Impatient
Independent
Insecure
Jealous
Lonely
Loss
Love Music
Loving
Motivated
Need company
Needy
Non assertive
Observant
Optimistic
Organized
Panic attacks
Pessimistic
Poor memory
Procrastinate
Regretful
Religious
Resentful
Restless

Righteous
Sadness
Secretive
Self-esteem
Self-pitying
Sensitive
Sentimental
Serious
Sexual
Spiritual
Stubborn
Suicidal
Suicidal thoughts
Swearing
Talkative
Tense
Thrifty
Tidy
Trouble concentrating
Unaffectionate
Unemotional
Unforgiving
Uninterested
Violent
Weepy
Workaholic
Worried

Prefer outdoors/ indoors? ______
Tolerate temperature change? ______
Food desires? ______
Food aversions? ______
Like solitude/company? ______
Like attention when unwell? ______

Favorite season? ______
Favorite color? ______
Drinks desires? ______
Drinks aversions? ______
Like touch from others ______
Sleep position? ______

Hobbies/sports____

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I.. State all information given above is to the best knowledge, all true and correct. I understand the homeopathic intern is not state licensed. (There is no License in the State of California) Signed by parent or guardian. ***To cancel or reschedule an appointment, please do so 5 days prior to the appointment or there is a charge.***

Signed..…………......................Date....…….…........

LOS ANGELES HOMEOPATHIC CLINIC
ACKNOWLEDGMENT, CONSENT AND RELEASE WAIVER

Welcome to Los Angeles Homeopathic Clinic

The Los Angeles School of Homeopathy Clinic is a teaching Clinic. Our purpose is to provide excellent Homeopathic care to you, and a learning environment for student interns to gain knowledge and experience in the practice of Homeopathy. A Clinic supervisor will supervise our interns and oversee every Homeopathic consultation in the Clinic.

Due to the limited hours available to interns and supervisors, you may not be able to see the same intern or supervisor for every appointment, although we try to accommodate consistency throughout your Homeopathic care. The school has no availability for treatment in-between scheduled appointments. We can only address your issues while at your schedule appointment time.

To further the mission of Los Angeles School of Homeopathy, client Clinical records may be reviewed as needed by the faculty at the school. Results may be published in Homeopathic Journals to further the course of Homeopathic *care*. All personal information will remain confidential. You must submit a written request that your case not be included in any research publication.

1. I agree to be interviewed by a Los Angeles School of Homeopathy intern who will report to an on-site supervisor. I understand the interview may include questions about physical, emotional, mental and spiritual issues concerning myself. <u>I understand the results of Homeopathic care are not guaranteed.</u>

2. I am over the age of 18 years. I have read this document and am fully familiar with its contents. I have executed this document freely and voluntarily, and without any promises by Los Angeles School of Homeopathy, except those, if any, expressly contained in this document.

3. Payments: By signing below you agree to have your card on file and charged for any serviced rendered.

4. This document will be binding upon me, and I release any responsibility against, my heirs, executors, administrators, successors and assigns, and will ensure to the benefit of Los Angeles School of Homeopathy, and their heirs, executors, administrators, successors and assigns.

5. Agreement to Arbitrate: I agree to arbitrate any disputes as provided by California state law, and not by a lawsuit. By entering into this contract I am giving up the constitutional right to have any such dispute decided in a court of law before a jury. All claims must be arbitrated.

6. I understand and agree that I will be videoed and recorded, as other interns will view my case via video.

As a non-profit Clinic, we adhere to the following office policies:

a) Clients must inform us 5 days in advance of a cancellation/reschedule of an appointment or there is a charge for that missed appointment.
b) Please make the commitment to your first visit and at least two follow-up visits.
c) Most homeopathic remedies will need to be picked up by you at a local homeopathic pharmacy. The cost of a remedy is usually around $10.00 or less.
d) The fee is $85.00 for the first visit and $45.00 for the follow up visits. There is also a sliding scale if needed.
e) At the time of booking your initial appointment**,** a credit card will be necessary to hold your appointment. Your card will be charged at the time of your appointment and not before. You can also pay via Venmo or Zelle, if arranged at the time of the appointment, payments are due at the time of service. If we ship you any remedies or order them on your behalf, we will charge you for those.
f) Credit card information: Patients will be responsible for updating the credit card on file as needed throughout treatment.

CALIFORNIA SENATE BILL SB-577 ~ WHAT IT MEANS FOR CLIENTS

California Senate Bill SB-577, which was signed by the governor in September 2002, has profound implications for the practice of alternative forms of health care in California. SB-577 enables alternative and complementary health care practitioners to provide and advertise their services legally. However, they must also comply with certain requirements specified within the bill.

What does Senate Bill SB-577 mean for you, the client?

SB-577 gives you access to alternative and complementary health care practitioners. You must be given information about the nature of treatment and the practitioner's qualifications. Feel free to ask a practitioner any question you might ha about your treatment. Check to see if your practitioner has been certified by a professional membership society. In additio tell your doctor about any alternative treatment you are pursuing. You can also request that your licensed and unlicensed health care providers communicate with each other and work collaboratively to meet your health care needs.

SB-577 helps to protect you. SB-577 requires unlicensed alternative health care practitioners to follow certain guidelines restrictions.

Here are the things that unlicensed alternative practitioners are NOT allowed to do:

- Perform any form of surgery or any procedure that punctures your skin or harmfully invades your body.
- Use X-ray radiation.
- Prescribe prescription drugs, or recommending that you discontinue drugs that were prescribed by a licensed physician.
- Set fractures.
- Treat wounds with electrotherapy.
- Put you at risk of great bodily harm, serious physical or mental illness, or death.
- Imply in any way that they are licensed physicians.

In addition, an unlicensed alternative practitioner MUST DO the following things:

- Provide you with a statement, written in plain language that includes the following information:
  (1) That they are not a licensed physician and that their services are not licensed by the state;
  (2) A brief and clear description of the kind of services they provide and the reasoning behind it;
  (3) A description of their education, training, and experience.

By signing below, I agree to the terms above.

Print Name: ____

Signature: _____________________________________ Date: _____________