Nadine Leonova, D.Hom

Classical Homeopathy · Online consultations by video · returnto.health

Homeopathic Consultation Questionnaire *for your child*

Thank you for taking the time to fill this out before your child's first appointment. Write as much or as little as feels right; we will go through everything together during our consultation.

CONTACT DETAILS

Child's full name		**Child's date of birth**
Parent or guardian name(s)		**Best parent to contact**
Cell phone	**Email**	**City, State, ZIP**
Time zone ☐ Pacific ☐ Mountain ☐ Central ☐ Eastern ☐ Alaska ☐ Hawaii ☐ Other: _____		
Preferred contact method ☐ Phone call ☐ Text message ☐ Email		**Referred by**
Name of child's present MD	**Family situation** (optional)	

CURRENT HEALTH CONCERNS

Please list your child's current health concerns
Have you seen an MD for your child's current condition? ☐ Yes ☐ No If yes, what were you told?

BRIEF PAST HISTORY

Past major illnesses with approximate dates or ages	**Past hospitalizations and surgeries** with approximate dates or ages

MEDICATIONS, SUPPLEMENTS AND REMEDIES

Please include the name, dose and roughly when your child took each one, if you know.

Current conventional medications	**Past conventional medications**
Vitamins, supplements and natural therapies	**Homeopathic remedies your child has taken** with potency and result, if known
Adverse reactions to medications, vaccines or other treatments	

GENERAL WELLBEING

A few words for each is plenty.

Sleep quality, position, dreams, fears at night	**Energy through the day** best and worst times
Appetite food cravings or aversions	**Thirst** how much; cold, room temperature or hot drinks
Temperature does your child tend to feel hot or cold?	**Mood and stress** how your child feels and copes
Pregnancy and birth mother's health in pregnancy, type of birth, any complications	**Early development** feeding, teething, sitting, walking, talking
School and temperament learning, friendships, personality	

BRIEF FAMILY HISTORY

Please describe the state of health of family members, including major illnesses. If known, note the age at which an illness started and, if deceased, the age at which your relative died. (Relatives here are your child's relatives.)

Father	**Mother**
Father's mother	**Mother's mother**
Father's father	**Mother's father**
Brothers and sisters	**Other family information**

DISCLOSURE AND AGREEMENT

Before we begin working together, California law (Business and Professions Code §2053.5) asks me to tell you, in writing, a few important things about who I am and what I offer. Please read them carefully, and sign below to confirm that you have read and understood them.

- **I am not a licensed physician.** I am not a medical doctor.
- **Homeopathy is an alternative or complementary approach.** The care I offer is alternative or complementary to the healing arts services licensed by the State of California. My services are not licensed by the State of California.
- **What I offer.** I offer classical homeopathic consultations by video. In a first consultation we talk in depth about your child's health, history, temperament and general wellbeing. I may then recommend a homeopathic remedy, and we meet again for follow-up appointments to review progress.
- **The theory behind homeopathy.** Classical homeopathy is based on the principle of "like cures like." A single remedy is chosen to match the whole person, including physical, emotional and general characteristics, and is given in a small, highly diluted dose. The aim is to support the body's own natural ability to heal and find balance.
- **My training.** I hold a Diploma in Homeopathy (D.Hom) from the Los Angeles School of Homeopathy.
- **What I do not do.** I do not diagnose disease, and I do not prescribe drugs.

By signing below, I confirm that I have read and understood this disclosure, and I agree to the following:

- I will seek medical advice from a licensed medical doctor for my child's present and future health conditions.
- I will change or stop my child's prescription medications only under the supervision of a medical doctor.
- I will pay for each appointment, and I will pay the full charge for any appointment missed or cancelled with less than 48 hours' notice.

You may sign by hand, or by typing the full name of the parent or guardian. Thank you. I look forward to working with you and your child.

Signature of parent or guardian (or typed full name)		**Date**
Printed name of parent or guardian	**Relationship to child**	**Child's full name**