ELLY TUCHLER A.P.

(For Children)

INTAKE FORM

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

If a child is given love, he becomes loving... If he's helped when he needs help, he becomes helpful. And if he has been truly valued at home... he grows up secure enough to look beyond himself to the welfare of others.

Dr. Joyce Brothers, Good Housekeeping, Aug. 2010.

Children are our most treasured possessions. Every parent aspires to give best upbringing to their child, especially good health.

Homoeopathic system of medicine is fast gaining popularly especially in pediatric ailments because of its gentle methods of cure with no side effects.

Homoeopathic medicine are helpful to children as they increase the resistance of an individual by boosting the immune system. Thus, they help the individual to fight against various diseases. Homoeopathy treats children as a whole rather than just their symptoms. Hence, a homoeopath will observe the child in terms of overall appearance, the way he/she behaves, answers the questions and his/her entire pattern of physical, emotional and mental characteristics.

Each child has its own imaginary world, which only he/she can explain; in a way he/she is the actor, director, producer of one's own life. This inner fantasy world of every child is a gateway for a homoeopath to enter into the child's realm. To help understand the child's innermost disturbance, it is vital to understand child's fears, dreams, fantasies, favourite cartoons, toys, T.V. programmes, movies, drawings, poetries etc.

The state of the mother during the pregnancy is one of the most important factors that helps in understanding a child. All the physical and emotional changes experienced by a woman during the pregnancy cast a big influence on the child. During this period, the child himself has not seen the world, but he/she is feeling, perceiving or sensing it through the mother. Hence, it is essential to understand how the mother thinks, feels, perceives and senses herself in the pregnancy period and the world around her. This can be recognized by the smallest of change in the nature, behavior, unusual dreams, fears, thoughts, emotions of mother, any alteration in the desire or aversion for food substances, any particular illness during this period etc.

The state of father during the period of conception is also at times significant to understand the constitution of a child. In such cases, we need to enquire about the father's feelings/thoughts/sensations during the period when they were planning to have a child.

Such homoeopathic treatment also improves the attitude of a child towards life, channelizes his/her potential, enhances creativity and performance to the best of his/her abilities.

All this information is essential and enables us to select the remedy. In order to find out all about the child, we shall be asking you (child or parent or guardian) several questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is of a lesser importance. Even something that you may think is not connected with the child's troubles may be the most important factor in deciding the correct homoeopathic medicine. That is why you must be free, frank and spontaneous and give a detailed information on each point. Please read each question carefully, think, and if necessary, consult someone close to the child and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential. We reserve the right to use this information provided by you for our in-house research or statistical purpose.

THIS QUESTIONNAIRE HAS 7 PARTS:

1. Description of the main complaint/complaints.
2. About the past illnesses, vaccination details and the developmental history. It also includes details of medical history of family members. Please take time to answer this part with the help of your family members before coming to us.
3. Personal history that covers all allergies and addictions, likes, dislikes etc.
4. Deals with the factors that affect the health of the child. Please think carefully about each of the factors mentioned and write what specific effects they have on your child.

5. About the mental state and emotional nature. Please write in this part about situations in life and about all the things that are bothering the child. Be totally frank and open.

6. Parts of the body affected.

7. Mother's history during pregnancy.

Note:

1. This is an opportunity to put into words all that is bothering your child. The most important thing is to use your child's own words/phrase what he/she often says as far as possible rather than mentioning what you perceive about your child.
2. If possible let the child fill this form himself/herself. And if the child wishes to keep it confidential let be.
3. Parents can discuss what they have to personally with the homoeopath.
4. It is preferred that the patient fills the form, rather than typing it. If in any case, the patient has any difficulty in filling the form, or cannot fill the form, he is requested to call the clinic for necessary help in filling out this case record.

C O N F I D E N T I A L

Date: .....

Name: .....

(Begin with Surname)

Date of Birth: ..... Age:..... Sex: Male/Female.....

Name of Father: .....

Name of Mother: .....

Address:.....

..... Nationality:.....

Telephone (Residence): .....

Mobile: (Father) ..... (Mother) .....

E-mail Father: .....

E-mail Mother: .....

Vegetarian/Non Veg./Egg. Veg.

Name of School: ..... Education: .....

Occupation of Parents (Nature of Work):

Father ..... Mother .....

Address of Work Place:

Father :.....

.....

..... Tel.: .....

Mother :.....

.....

..... Tel.: .....

Referred to us by: .....

Part 1 - Details of Present Illness:

In Homoeopathy, prescription is based on precise details of various complaints that the child has, mere mention of a complaint does not suffice for a good prescription. Please follow the instructions given below for helping us understand your child's complaints.

We require the following details about your child's symptoms.

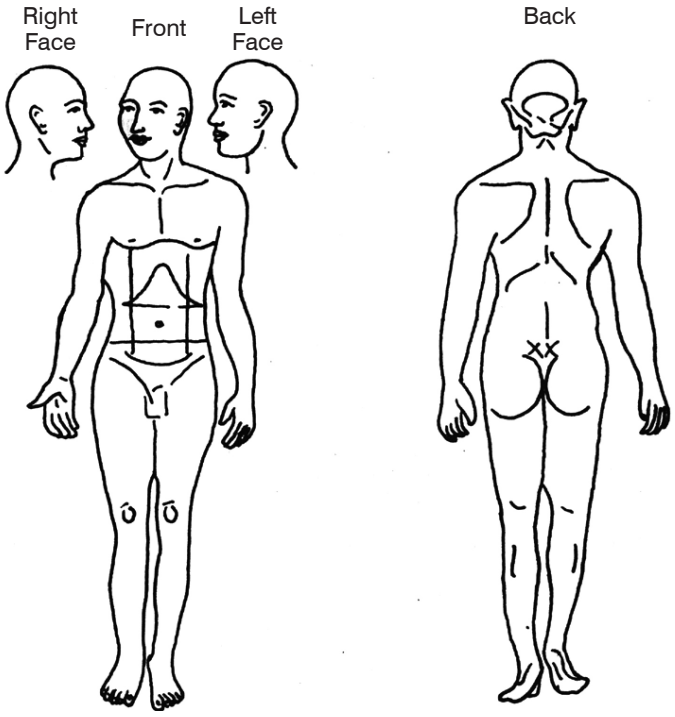
What are the complaints?

Since when is the child having these complaints?

Location: Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads.

Please mark the locations of your child's trouble in the chart given below:

(*You can also mark the other parts of the body which are affected by writing the complaint next to each e.g. head - pain.*)



SENSATION: Express the type of sensation or the pain that he/she gets in his/her own words, however simple or funny it may seem. Express the sensation or pain as it feels to him/her. Be free to describe the pain and his/her experience with the same in child's own words.

Origin of cause: Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexposure to cold, heat etc.)

What are the factors that influence your child's health? e.g. weather, food, pressure, anxiety etc. or any other (Please refer to part 4 on page 15 and 16 for a detailed list of the factors)

Please mention how each factor affects the child whether it increases or decreases his/her complaint, and also how much does it affect child's complaint. (e.g. headache worse by even little exposure to sun, headache better by pressing the head)

Describe each of the complaints in the table given below:

Where is the trouble?	What exactly does he/she feels?	What are the factors that make this trouble better or worse?

Part 2 - Past History & Family History:

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, affecting us much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus the body is strengthened. So, it is necessary for us to know about all the ailments that the child has suffered from in the past and the treatments you have given.

In the list below, circle around the names of all major illness so far suffered and on the next page give their relevant details.

<table>
<tr><td>Typhoid
Cholera
Food poisoning
Worms
Diarrhoea
Dysentery</td><td>Measles
German Measles
Chicken-pox
Small-pox
Mumps
Whooping cough</td><td colspan="2">Malaria
Jaundice
Any Liver, Spleen or
Gall bladder disease</td></tr>
<tr><td>Malnutrition
Rickets
Rheumatism
Backache</td><td>Any venereal disease like Syphilis Gonorrhoea etc.</td><td>Any Heart trouble
Blood pressure
Giddiness</td><td>Nephritis (Kidney or urine trouble)
Diabetes</td></tr>
<tr><td>Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles Uterus, Renal stones, Gall stones, Phimosis, Hydocele, Cataract etc.
Mode of anaesthesia: General/Local</td><td colspan="2">Diphtheria, Septic Tonsils, Adenoids Recurrent infections, Sinusitis, Bronchitis, Eosinophilia
Cold, Fever, Chills
Pneumonia
Asthma, Pleurisy, T. B.</td><td>Any serious shock, grief, disappointments, fright, mental upset, depression or nervous breakdown</td></tr>
<tr><td>Chronic Headaches Numbness
Cramps, Fits, Convulsions Polio, Paralysis etc.
Meningitis
Any Lumbar puncture done</td><td colspan="2">Any major accident or injury to body or head
Any occasion of unconsciousness
Any major bleeding from any part of the body</td><td>Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema, Herpes, Urticaria, Allergy, Ulcers on any part of the body</td></tr>
</table>

Please mention if your child has suffered from any other diseases apart from one mentioned above.

Details of past illness of your child:

Diseases suffered from	Approximate Age	Duration	Medication taken	Whether he/ she completely recovered	Any other particulars

Mention any drugs, tonics, stimulants etc. that have been given to the child at any time in life.

Vaccination History:

Vaccine given	Age	Complaints after vaccination	Duration (for how long did they last)	Any other particulars

Family History: (To be filled by the parents only)

Please fill in the table given below after reading the list given.

List of major diseases - Anaemia, Cancer, Diabetes, Insanity, Rheumatism, T.B., Pleurisy, Leprosy, Epilepsy, Fits, Bleeding tendency, Urticaria, Eczema, Asthma, Paralysis, Hypertension, Heart trouble, Kidney disease, Liver disease etc.

Relationship	Alive/Dead	Age	Diseases suffered	Diseases suffering from since when?	Cause of death
Paternal Grand Father					
Paternal Grand Mother					
Maternal Grand Father					
Maternal Grand Mother					
Father					
Mother					
Paternal Uncles					
Paternal Aunts					
Maternal Uncles					
Maternal Aunts					
Cousin Brother & Sister on Father's Side					
Cousin Brother & Sister on Mother's Side					
Did any of your relatives (blood relatives) have trouble similar to yours					

Information about the child's siblings: Indicate child's position by writing his/her name.

Sibling's Name	Alive/Dead	Age	Male/Female	Diseases suffered

Developmental History:

No.	Milestone	At what age did the child start	Problems
1	Head holding		
2	Sitting		
3	Standing		
4	Walking with support		
5	Walking without support		
6	Teething		
7	Speaking		
8	Urine control		

Were there any other problems in growth & development of the child?

Part 3 - Personal History:

Allergy History:

Does the child suffer from any allergic conditions? If yes, please specify.

Also mention the items that you feel the child is allergic to.

If any specific allergic testing is done, then please mention and attach investigation reports.

Addictions:

What the child is addicted to like internet, games, shopping, any drug substances.
Is the child habituated to TV, games, internet, shopping or any other?

Appetite and Thirst:

How is the appetite?

When is the child hungry?

What happens if he/she has to remain hungry for long?

Does he/she has a habit of eating fast?

How easily does he/she feel full after eating? (e.g. soon/eating a lot etc.)

How much thirst does the child has?

How frequently does he/she drink and how much?

Is there any particular time that he/she especially thirsty?

Does he/she crave for cold/warm water/ice?

Please put one tick (√) if your child likes/dislikes the food or if the food disagrees. Put two tick marks (√√), if he/she strongly likes/dislikes the food or if the food strongly disagrees.

Please mention any other specific food items or drink that he/she really craves or likes at bottom.

Foods	Like	Dislike	Disagrees	Foods	Like	Dislike	Disagrees
Salty				Onion			
Bitter				Tea			
Spicy				Coffee			
Sour				Milk			
Sweet				Curd			
Exotic				Buttermilk			
Bread				Fruits			
Butter				Warm food			
Eggs				Cold food			
Chicken				Ice			
Red Meat				Ice-cream			
Pork				Cakes/Pastry			
Fish				Chocolate			
Fatty food/ Fried food				Cheese			
Cabbage				Any other			

Urination & Urine:

Any problem about urination?

Any strong smell of urine? What is it like?

Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling etc.?

Any involuntary urination? When?

Is there any complaint of bedwetting?

Any complaint of involuntary urination?

Does the child cry before/during/after urination?

Stool:

Is there any problem regarding stools?

When and how many times in a day does he/she pass stools?

Is he/she satisfied after passing stools?

When is it urgent?

Does he/she has to strain for stool? Even if soft?

Does the child cry before/during/after passing stools?

Sweat/Perspiration - Fever - Chill:

How much does he/she sweat?

On what part does he/she sweat the most?

Does the sweat smell? What is the kind of smell?

Does the sweat stain the clothes? What colour?

Any complaints after sweating?

Is there perspiration on the palms or soles?

When does he/she get fever or chill?

What brings it on?

With fever which part feels hot?

With chills which part feels cold?

Does he/she experience any sense of heat or cold in any part of the body at particular time?

Does he/she has burning or heat or cold feeling in the palms or soles?

Sleep:

Describe what is the posture during sleep e.g. on back, abdomen, sides?

How is the sleep pattern?

Is the child able to sleep in any position? In which position is he/she uncomfortable?

During sleep does the child grind teeth/dribble saliva/sweat/keep eyes or mouth open/walk/talk/moan/ weep/become restless/wake up with a jerk etc.?

Describe if anything unusual about the sleep.

How much does he/she cover/uncover any parts?

Dreams:

Circle types of dream that the child has.

Animals/Cats/ Dogs/Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death: Whose? Dead bodies Dead persons Part of body Suicide	Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain
Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work	Vomiting Passing stool Urinating Blood-bleeding Excrements/ soiling	Romantic Sexual-pleasure Rape Nakedness	Pain Sickness Mutilations	Praying Religious Temple Church God
Failure/ Exams Unsuccessful efforts? For what? Missing Train Being unprepared	Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom? - For what?	People Children Parties/Feasts Marriage	Of events Remote Recent Future Prophetic	Physical Exertion Mental Exertion Fatigue Coloured Multi-Coloured

If any other, specify in the space below.

Sensitivity to Heat and Cold:

Which season does the child like?

Which weather can he/she not tolerate?

How much covering does the child require (thick/thin)?

Summer:

Winter:

How much fan does the child want (slow/fast/moderate/no)?

Summer:

Winter:

Which water does he/she bathe with (tap, lukewarm and hot)?

Summer:

Winter:

Sexual Sphere (General):

Does the child masturbate? What is the frequency? What is its effect?

Any history of sexual abuse?

Did the child ever suffer from any infection of the genital organs?

For Boys:

Any problem in the genital organs?

For Girls:

Any dryness, itching, discomfort, bleeding, burning or pain in vagina?

Menstrual History:
At what age did the menses start?

How are the periods: regular or irregular?

How many days is her monthly cycle?

Was there any complaint when the menses first began?

Menstrual Flow:
Duration (days): How long do the menses last?

How much is the flow? (E.g. profuse, scanty, moderate):

What is the color of the flow?

Is there any smell of the flow?

Do the menses stain? If yes, what is the color?

Are the stains difficult to wash?

Are there any complaints before, during or after menses? If so, describe.

Is there any white discharge?

If yes, mention the quantity, color, consistency and smell of discharge.

When and under what circumstances is it more or less?

Does the discharge have any relation to menses?

Is there any complaint due to discharge? (E.g. itching, burning, discomfort or any other):

Any trouble with breasts?

Part 4: Factors affecting the child:

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor on the overall health of the child esp. on his/her complaints (whether it increases/decreases or affects the complaint in any peculiar way).

For instance take the factor 'Sun'. Suppose by going in the sun the child gets a headache then write 'Headache' opposite to 'Sun'.

If in hot weather the child feels uneasy, then write 'Uneasy' opposite to 'Hot weather' in the column.

Especially write the effect each factor has on the main complaints. For instance if the main complaint is Asthma and this is worse when lying on the back then opposite to 'lying on the back' write 'Asthma becomes worse'.

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause headache but make you feel better in general. If this is so, please mention this difference clearly.

Factors	Effect
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunderstorm	
Covering	
Sun	
Warm bath	
Cold bath	
Fanning	
Air-Condition	
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding in bus, car etc.	
Sitting	
Sitting erect	
Standing	
Stooping	
Lying	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	
Lying with head low	
Looking up	
Looking down	
Looking from high places	

Factors	Effect
Looking from moving object	
Noise	
Sudden Noise	
Music	
Light	
Before urine	
During urine	
After Urine	
Before stools	
During stools	
After stools	
Before menses	
During menses	
After Menses	
After sweating	
When fasting	
After eating	
Over eating	
Belching	
Passing gas	
Drinking	
When constipated	
Vomiting	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Open air	

Factors	Effect
Biting or chewing	
Blowing Nose	
Physical exertion	
After sexual intercourse	
Dust	
Smoke	
Touch	
Pressure	
Massage	
Tight Clothes	
Before Sleep	
During Sleep	
After Sleep	
After afternoon nap	
Loss of sleep	
Yawning	
Sneezing	
Coughing	
Laughing	
Talking	
Reading	
Writing	
After hair cut	
Combing hair	
Brushing teeth	
Moving the eyes	
Opening the eyes	
Closing the eyes	

Factors	Effect
Opening the mouth	
Strong smells	
Smoking	
Hanging the limbs	
Raising the arms	
Near Sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Getting feet wet	
Working in water	
Moonlight	
Full Moon/New Moon	
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After Weeping	
When alone	
In company	
Consolation/Sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Any other	

Part 5: Mind:

In order to understand the emotional and intellectual nature of the child, we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving the correct remedy. Also such a remedy will help improve mental make up of the child.

1. What is the effect of main complaint and associated complaints on the child?

2. Describe the unusual sensation they experience during stressful situations like nightmares, fears, before exam, with any incident.

3. What are his/her fears (existing and/or imaginary)?

4. Any incident which had a deep impact on him/her? Describe in detail.

5. What are the stories/fairytales that he/she likes to read/listen to?

6. What are his/her imaginations/fantasies? Describe in detail.

7. What dreams does the child get or had?

8. What are the nightmares that he/she gets or had?

9. What are his/her interests and hobbies?

10. Describe about the specific toys, games/specific TV serials, cartoon characters, movies the child likes.

11. How is he/she at sports and other activities?

12. Describe about the drawing and coloring he/she likes.

13. What are the other activities the child likes to do?

14. Describe all the qualities of your child, which makes him/her different from other children, which is unique to him/her.

15. What does he/she wants to become when he/she is grown up and why? What are his/her ambitions?

16. Whom does he/she idealize and why? What is about him that he/she admires the most?

17. How is his/her behavior with parents, teachers, friends relatives? What are the qualities he/she admires in them?

18. How is his/her behavior in school and what is his/her teacher's opinion about the child?

19. What kind of questions does he/she asks to parents, relatives and teachers?

20. What are his/her views about the city, state, country and world?

21. What makes your child cry or laugh?

22. What makes your child very angry and irritable?

23. What does the child do when he/she is alone?

24. What are your child's first five wishes?

i)

ii)

iii)

iv)

v)

Please tick mark once (√) if the child has any of the following qualities: Tick mark twice (√√) if they are more intense:

	Tick here		Tick here
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like:	
Hyperactivity		Biting nails	
Destructiveness		Thumb-sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition - winning spirit		(b) shawls, handkerchiefs	
Sibling jealousy		(c) anything else	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness/Indolence	
Telling lies		Sensitive/Emotional	

For your child:

Please tell the child to draw something which comes to his/her mind at this very moment or the favourite drawing.

Part 6: Parts of body affected:

Any complaints about:

Vertigo: Does your child have giddiness - vertigo?

Faintness: Does he/she ever feel faint? When?

Head: Does the child get headaches?

Eyes & Vision: e.g. redness, burning, difficulty in reading etc.

Ears & Sense of Hearing: e.g. ear pain, difficult hearing etc.

Nose & Sense of Smell: e.g. bleeding from the nose, any problem with smell etc.

Face & Facial Expression: e.g. acne, pigmentation, moles, warts etc.

Mouth: e.g. ulcers, bad smell from mouth etc.

Teeth & Gums: e.g. carries in teeth, stained teeth, bleeding or swollen gums.

Tongue & Sense of Taste: any cracks, coating etc.

Lips: cracked, peeling of skin etc.

Throat (including tonsils): e.g. pain, difficulty in swallowing, trouble with voice or speech etc.

Cold & Cough: Does the child catch cold often? What factors generally bring on the cold?

Describe the symptoms during cold, nature of discharge from nose etc.

Does he/she get cough? What brings on the cough?

Is it more at any particular time?

Breathing: Any difficulty in breathing?

How frequent is it?

What brings it on or makes it worse/better?

Back & Limbs: Does the child have any trouble in back, limbs or joints? Describe in detail?

If there are pains, do they extend in any direction or shift?

What brings on the pains or makes them worse/better?

Is there any abnormality, swelling, numbness, paralysis etc. in any part of the body?

Skin: Does the child have complaints like itching, eruptions, ulcers, corns, peeling, change in color, spots etc.? If yes, describe.

Nails: Is there any complaint or abnormality of the nails or the skin around?

Hair: Is there any complaint with the hair such as falling, graying, dandruff, dryness, oily, poor/excessive/ unusual growth?

General:

Do the wounds take a long time to heal?

Is there any tendency for formation of keloids or pus?

Does the child has a any tendency to bleed?

Is there any trembling? When?

Is there any sense of weakness? Where?
When is it more and what causes it?

Part 7: Mother's history during pregnancy: (To be filled by mother only)

1. Was the pregnancy planned or unplanned?

2. Describe the circumstances around the period of conception? (Stressful if any)

3. What changes you have observed within you?

4. Tell the changes you noticed in your nature and behavior from the time you conceived till you delivered the child.

5. Anything unusual or peculiar phenomena you observed only during pregnancy that you think were not a part of your routine nature and that occurred with the pregnancy?

6. Any incident during pregnancy that had a deep impact on you? Describe your feelings, thoughts or any sensation associated with it.

7. What were your dreams during pregnancy (Also mention dreams around the time of conception, if any)? Did you have any unusual, recurrent dream that had a deep impact on you?

8. What were the thoughts, fantasies and imaginations about your child during pregnancy?

9. Did you have any unusual thoughts during that period? Describe in detail. What was your reaction to that?

10. Did you experience any unusual bodily sensation/movement during this period? Describe the whole experience.

11. Did you have any fear or nightmares during this period? Describe it.

12. Was there any change in your interests and hobbies during pregnancy?

13. Did you observe any change in your relationship with people during this period? What was it?

14. What were the changes in the likes/dislikes of any particular food during pregnancy?

15. Was there any change in your sensitivity to heat/cold during pregnancy?

16. Any change you observed in your general pattern for e.g.

Appetite
Thirst
Perspiration
Sleep
Bowel movements
Urination
Sexual desire

18. Did you suffer from any disease during pregnancy?

19. Were you on any medication during pregnancy?

20. Any addiction during pregnancy?

Delivery history:

Was it normal?

Was the delivery full term/early/delayed?

Was it Caesarian section/forceps/vacuum delivery? Any other procedure done?

Please attach with this form:

1. All medical reports from physicians consulted and opinion on your child's state of health.
   Recent copies of investigations done. E.g. C.B.C., E.S.R., U.S.G., X-ray etc.
2. Please mention if your child has taken any Homoeopathic Medicine. Brief us with the name of the medicine he/she has received along with his/her response to the same. (If you are aware of).

Kindly let us know what was your experience while filling this form.