

Which of the following ailments, or any other major ailments, have affected your child's relatives:

- | | | | | | | |
|--------------|------------|--------------|---------------|----------------|------------|-----------|
| Alcoholism | Allergies | Arthritis | Asthma | Cancer | Depression | Diabetes |
| Epilepsy | Gonorrhoea | Gout | Heart Disease | Mental Illness | Paralysis | Pneumonia |
| Skin Disease | Syphilis | Tuberculosis | | | | |

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Previous pregnancies by natural mother, miscarriages or complications?

Mother's age at child 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? _____ **How long?** _____ **Formula?** _____ **Milk/Soy or other?** _____

Food Intolerances? _____ **Age began solid foods?** _____

Is there any other information that I need to know?

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.)

I, the undersigned, understand that Lisa Decandia is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Lisa Decandia, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my child's consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Parent Signature: _____ Date: _____

Witness: _____