NEW CHILD INFORMATION

NAME_____ Birthdate_____
Mailing Address_____City_____Zip_____
HOME PHONE_____ PARENTS WORK PHONE_____
Parent's Cell_____
Family email address _____ FAX _____

IN THE EVENT OF EMERGENCY PLEASE NOTIFY
Name_____PHONE_____

How were you referred to Dr. Carlston ?_____
Prior homeopathic treatment ?___By Whom_____Date Last Seen_____

MEMBERS OF THE HOUSEHOLD

NAME	AGE	RELATIONSHIP TO PATIENT

WHO SPENDS THE MOST TIME CARING FOR CHILD?_____
OCCUPATIONS OF PARENTS/GUARDIANS_____

ALLERGIES (please list all known or suspected drug sensitivities as well as environmental allergies)

_____
_____

MEDICATIONS AND VITAMINS (include non-prescription)

NAME	DOSAGE	FREQUENCY

CHILDREN

HEALTH HABITS

Have You Made Your Home As Safe For Your Child As Possible ? (Consideration only, no answer needed)

Do you believe your child gets enough exercise ?_____

Does anyone smoke in the home ?____

Does the child always wear seat belts riding in an automobile ?_____

Does your child watch television or videos ?_____ How many hours each week ?_____

IS YOUR CHILD EXPOSED TO ANY TOXIC SUBSTANCES ? (Please provide details regarding those exposures that are of concern)_____

_____

_____

_____

WHICH HEALTH PROBLEMS ARE YOU PARTICULARLY CONCERNED ABOUT ?

_____

_____

_____

WHAT RECENT LOSSES OR UNUSUAL STRESSES HAS THE CHILD EXPERIENCED?

_____

_____

_____

PLEASE CIRCLE ANY DISEASES THAT HAVE OCCURRED IN EITHER FAMILY

Alcohol/Drug Problems Allergies Alzheimer's Disease Anemia Arthritis/Gout

Asthma Bleeding Problems Cancer Convulsions/Epilepsy Diabetes

Eczema Emphysema Heart Trouble Hepatitis High Blood Pressure

Kidney or Bladder Problems Mental Illness Migraines Pneumonia Polio

Rheumatic Fever Stomach or Intestinal Disease Stroke Thyroid Problems

Tuberculosis Ulcers Venereal Disease Weight Problems