Anke Zimmermann, BSc, FCAH
Classical and Modern Homeopathy
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CHILDREN'S FORM – GENERAL CONCERNS

Please use the Autism/Developmental/Behavioural Concerns intake form if your have concerns about those areas.
This is a word document, please type into the from if possible or else make sure to write carefully and legibly, thank you.

Date _____

Name _____

Date of birth _____ Present Age: _____ Blood group if known: ____

Mother's name_____

Tel. Home: _____

Tel.Office/cell_____

Father's name _____

Tel. Home: _____

Tel.Office/cell_____

Email (only used for office communication) _____

Child's primary address, Street address _____

City _____

Province/State:_____ _____Postal Code: ___ __

Country_____

Siblings, names and ages _____

_____

Health Care Practitioners _____

_____

_____

Who referred you to this office: _____

Would you like to receive my newsletter, sent out about 4 times a year? _____

Dear Parent,

Welcome to my office. This questionnaire will help you to organize your thoughts for our initial meeting. Clients find the timeline especially useful. I am the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please contact office and I will help you to decide how best to solve the issue.

The majority of my consultations are virtual these days, however, I occasionally see clients in person. If you come in person, please come smoke and fragrance free. Please also note that a dog and a couple of rabbits live in my house in case you are allergic.

FEE SCHEDULE

Initial consultations include research on your child's case and often a preliminary treatment plan, please note I sometimes need another, shorter consultation before being able to create an initial treatment plan.

(Fee schedule is subject to change without notice.)

Initial Consultation, regular 60 minutes	$400.00
Regular Follow-Up, 30 minutes	$120.00
Quick Check-in, 15 minutes	$ 65.00

Telephone consultation.....varies with amount of time spent
Email consultations…… minimum 15 minutes, $55.00
NSF cheques.....$30.00
Medical - Legal reports.....varies with amount of time spent
Failure to keep a scheduled appointment.....cost of scheduled visit

All fees must be paid at the time of the visit including services, remedies and supplements and costs of laboratory tests.

Please note: Form of payment is cash, cheque, debit, credit, email transfer or paypal.

ACKNOWLEDGMENT

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In order to avoid any confusion or misunderstanding, Anke requests that all clients read and acknowledge the following:

- That you understand that Anke Zimmermann works within the homeopathic scope of practice, is not a medical doctor, and employs some methods which are not orthodox medical practice at this time e.g. Applied Kinesiology.

- That you understand that Anke Zimmermann uses non-invasive methods for the assessment of bodily dysfunction, and natural therapeutics for their correction, mostly homeopathy.

- That you understand that the services here and/or referral to other health professionals is based upon the assessment of health status revealed through personal history and interview, physical assessment, laboratory testing and other testing.

- That you understand that you are responsible for any fees incurred while under care. Homeopathic care is covered under certain private insurance plans, and I will do my utmost to provide the appropriate documentation to your insurer upon request.

- That you are here as a client and are not attending my office for any other reason without making your intention known to myself or my staff.

Please be informed that you are required to give at least 1 business day notice in case you need to cancel or reschedule any appointment, including the initial one. Anke regrets that otherwise she will need to charge you for the missed appointment.

She greatly appreciates your consideration in this matter.

_____ _____

Date Patient's/Guardian Signature

Consent for Care

Anke Zimmermann, BSc, FCAH will take a thorough case history, and may perform a physical examination related to your concerns if desired and indicated.

It is very important that you inform Anke of any disease process that your child is suffering from and any supplements/medications/over the counter drugs that he or she is currently taking.

There are some health risks associated with the use of homeopathic remedies, herbs and supplements. These include but are not limited to the following:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Homeopathic remedies may stimulate healing or detoxification reactions, which may include loose stools, increased perspiration, skin eruptions and nasal discharges among others. These reactions are uncommon and normally pass within a few hours to days.
- Herbal tinctures can taste bad and may occasionally cause headaches or stomach discomfort.
- Nutritional supplements sometimes cause stomach discomfort.
- Some people experience allergic reactions to certain supplements and herbs. Please advise Anke immediately if you think that your child has experienced an allergic reaction.
- Please let Anke know immediately should your child experience any negative side-effects from any of your homeopathic and wellness care.

Important points to note:

- **Anke Zimmermann does not guarantee results.**
- A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law. You are entitled to a copy of your records at any time and to transfer of your records to another practitioner if desired, however, you are responsible for any costs of photocopying and mailing.
- Anke will explain to you the exact nature of any care provided and will answer any questions you may have to the best of her ability.
- You are free to withdraw your consent and to discontinue are at any time.

I certify that I have read and understood the above **Consent for Care.**

Patient Name: (Please print name): _____

Signature of patient or guardian: _____

Date: _____

Confidential Client Information

1. What is the main reason your child is attending this office? If this involves a specific health concern, please describe it in detail. In your own words, list the very first time that you noticed this concern and describe carefully any factors that you suspect may have played a role in its onset and development.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4. If this is a chronic condition how long has it been present? _____

Who diagnosed this condition? _____

When was this diagnosis made? _____

What specialists have been seen and when? _____
_____
_____
_____
_____
_____

5. How has this illness been treated until now, and what results have been obtained to date?
_____
_____
_____

_____

6. What other objectives do you have as far as your child's health is concerned? If these objectives are related to specific health conditions, then also advise as to how long these conditions have existed.

_____

_____

_____

_____

_____

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_____

_____

_____

7. How long has it been since your child was totally well? _____

8. Please list the 5 (or less) most significant, stressful events in your child's life, from the most recent to the most distant. Are any of these situations continuing to impact his or her life? If so, please indicate these clearly.

a. _____

_____

b. _____

_____

c. _____

_____

d. _____

_____

e. _____

_____

9. Are you/your child currently working with a professional counselor, psychologist, social

worker, or other therapist? Please provide details: _____

_____

10. Has your child had homeopathic care before? Please provide details:

_____
_____
_____
_____
_____
_____
_____
_____

Each line below represents a year in your child's life. Please draw a timeline of all major events in his or her life. This will aid me in my assessment of your child. Please indicate in

chronological order all vaccinations, accidents, illnesses, hospitalizations, surgery, broken bones, sprains, falls, traumatic and emotional events, major changes in your family's and your child's life up to this point in time. Please also indicate when he or she started school, changed schools, graduated, etc. This is a word document and will adjust if you need extra space.

Birth _____
Month 1 _____
Month 2 _____
Month 3 _____
Month 4 _____
Month 5 _____
Month 6 _____
Month 7 _____
Month 8 _____
Month 9 _____
Month 10 _____
Month 11 _____
Month 12 _____
Month 13 _____
Month 14 _____
Month 15 _____
Month 16 _____
Month 17 _____
Month 18 – 24 _____

Age 1_____
Age 2_____
Age 3_____
Age 4_____
Age 5_____
Age 6_____
Age 7_____
Age 8_____
Age 9_____
Age 10_____
Age 11_____

Age 12_____
Age 13_____
Age 14_____
Age 15_____
Age 16_____
Age 17_____
Age 18_____

Special Notes:

FAMILY HEALTH HISTORY

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR CHILD'S RELATIVES:

Alcoholism **Allergies** **Alzheimer's** **Arthritis**	**Asthma** **Cancer** **Depression** **Diabetes**	**Epilepsy** **Gonorrhoea** **Gout** **Hay Fever**	**Heart Dis.** **Hypertensn.** **Kidney Dis.** **Mental Illness**	**Paralysis** **Pneumonia** **Skin Dis.** **Digestive Disorders**	**Syphilis** **Thyroid Disorder** **Tuberculosis**

RELATIVE	AGE if alive	AGE if death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			