JENNADODGE HOMEOPATH

Baby / Infant - Initial Homeopathic History

Name: _____ Date: _____DOB: _____

Body Shape: _____ (Lean/Obese) Head Size: _____ Complexion: _____

Development

Age of 1st Baby Tooth: _____ Number of Teeth: _____ /Age: _____

Age Started to Crawl: _____ Age Started to Walk: _____

Anterior Fontanelle (soft spot): _____

Talking: _____
Example: One word by 1 Year/Two words by 2 Years/Makes sentences with two or more words

Tone of Body: _____ Facial Expression: _____
Example: Flabby Example: Smiling/Frowning

Facial Discoloration: _____
Example: Red lips/Cheeks/Pale

Modalities

Does baby lie in a certain way? _____

Does baby desire to be carried? YES or NO
Circle one

Does baby cling to parent? YES or NO
Circle one

Does baby cling to parent when picked up or put down? _____

Does warm or cold temperature help or aggravate symptoms: _____

What body parts are hot or cold? _____

How does baby react to baths? _____

How does infant react to uncovering and undressing? _____

How does the child react to the sun? _____

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Perspiration

Does the child perspire? _____How often does the child perspire? _____

How much does the child perspire? _____

When and where does the child perspire? _____

Is there an odor to the perspiration? YES or NO If yes, describe: _____

Sleep

Describe the child's sleep pattern: _____
Examples: Sleepless at night/sleepless during the day/Happy during the day and cries at night

Position in sleep: _____

What noises does the baby make while sleeping? _____

Are there any jerking or startling movements in sleep? _____

Is there restlessness of limbs on falling asleep? _____ Before falling asleep? _____

Are eyes open during sleep? _____

Appetite

How is the child's appetite? _____

Describe the frequency of feeding: _____

Food desires? _____

Unusual cravings? _____
Example: spicy/garlic/onions

Does the child eat inedible items? _____
Example: Paper, wood, dirt, clay, flour

List foods that cause aggravations: _____

List food allergies: _____

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Circle all symptoms that apply and if applicable, note if the child feels better after:

Colic: _____ Vomiting: _____

Burping: _____ Hiccups: _____

Flatulence: _____

Is the child thirsty or thirstless? _____

Is there a preference for cold drinks or hot drinks? _____

Stool

How often does the child have a bowel movement? _____

Describe Color: _____ Describe Consistency: _____

Is there anything in the stool? _____
Example: Undigested food or curdled milk

Personality/Disposition

Is the child talkative? _____ Does the child make eye contact? _____

Does the child have any fears? _____

What does the child do when they wake up? _____

Describe the behavior after eating: _____

Describe the behavior after bowel movement? _____

Is there any indication of regressive behavior? _____