# Classical Homeopathy Patient Information for Children

*Please print clearly.*

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work-Father_____ Work-Mother_____

Cell Phone: Father_____ Mother _____Email_____

Age _____ Date of Birth _____ Birthplace _____

Male ◉ Female ○ Weight _____ Height : Feet _____ Inch _____

Eye Color _____ Hair Color _____

Social Sec. No. _____

Grade in School: _____ Name of School: _____

Father's: Name _____ Age _____Occupation _____

Employer Name/ Address _____

_____

E-mail Address: Father_____ Mother _____

Mother's: Name _____Age _____Occupation _____

Employer Name/Address _____

_____

Siblings' Names, Genders and Ages _____

_____

Amount & Type of Exercise _____

_____

Describe Child's Diet _____

_____

Living Situation if Other than with Both Parents (any useful information)_____

_____

_____

I agree to the following: I accept full responsibility for all fees incurred. I agree to give two full business day notice if I need to cancel or change my child's appointment (e.g. a 1p.m. Monday appointment must be canceled no later than 1p.m. Thursday). If I fail to do so I agree to pay a cancellation fee of half the appointment cost (minimum $39.50). If my insurance company does not cover the full fees, then I am responsible for any fees not covered. I understand that fees are paid for the homeopaths time, and results cannot be guaranteed. I allow you to submit insurance forms on my behalf.

_____ _____

Parent Signature Date

# Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Classical Homeopathy, Inc. for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Classical Homeopathy, Inc. I understand that analysis, diagnosis or treatment of me by Classical Homeopathy, Inc. may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Classical Homeopathy, Inc. is not required to agree to the restrictions that I may request. However, if Classical Homeopathy, Inc. agrees to a restriction that I request, the restriction is binding on Classical Homeopathy, Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that Classical Homeopathy, Inc. has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Classical Homeopathy, Inc. and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Classical Homeopathy, Inc. The Notice of Privacy Practices for Classical Homeopathy, Inc. is also posted in the waiting room at 3326 S Geneva Street Denver, CO 80231 . This Notice of Privacy Practices also describes my rights and duties of the Classical Homeopathy, Inc. with respect to my protected health information.

Classical Homeopathy, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Classical Homeopathy, Inc. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representatives Authority

**Steve Waldstein RSHom(NA) CCH PCH**
**Classical Homeopathy, Inc.**
**3326 S Geneva Street**
**Denver, CO 80231**
**Tel: 303-338-1776**
**steve@homeopathy-cures.com**

The practice of Homeopathy in Colorado is regulated under the Colorado Natural Health Consumer Protection Act. Attached are disclosures required under this act. I am not licensed, certified or registered by the State of Colorado as a heath care professional, nor am subject to licensure, certification or registration by the State of Colorado. The nature of services to be provided is homeopathic health care.

My educational background for homeopathy is: I am of the generation of homeopaths who started the homeopathic schools in the U.S. When I originally trained there were no schools so like most homeopaths at the time we learned by self study and by seminars. Later I took a 2 years course in homeopathy taught by the Dynamis School and received a Practitioner in Classical Homeopathy Degree (PCH). I am board certified by the Council on Homeopathic Certification (CCH) and the North American Society of Homeopaths (RSHom (NA)). I was President of the North American Society of Homeopaths. I have been in practice since 1978. I am the author of "How to Choose the Diet That's Right for You."

We are required to recommend that you should discuss any recommendations I make with your primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician or other board certified physician.

We are covered by liability insurance applicable to any injury caused by an act or omission in our practice.

I agree that we have received this information as required by the Colorado Natural Health Consumer Act and have received a copy of this notice.

_____
Name of Client

_____
Name of Parent or Guardian

_____
Are You parents, guardian or ?

_____ _____
Signature of Parent or Guardian Date

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## For Parents or Guardians of Clients Who are Ages 2-7

Client Name ________

I give consent for us to treat your child.

We hereby state that I am not a physician pursuant to Article 36 of Title 12, C.R.S.

We are required to recommend that your child have a relationship with a licensed pediatric health care provider, and so we do recommend this.

Does your child have a relationship with a licensed pediatric health care provider?

Yes _____ No_____

If yes what is their Name and Address and Phone?_____

_____

_____

If yes, do you give permission for us to attempt to develop and maintain a collaborative relationship with the child's licensed pediatric health care provider? (If you answer yes we will call, write or email your pediatrician. If you answer no we will not.)

Yes _____ No_____

_____

Name of Parent or Guardian

_____

Are You parents, guardian or ?

_____ _____

Signature of Parent or Guardian Date

# FAMILY MEDICAL HISTORY

**Please fill out this form to the best of your knowledge. For each relative please state:**

1. If they are alive or dead.
2. If alive their age. If dead the age they died.
3. If dead what they died of.
4. Whether alive or dead, please list any health problems they suffered from at any time in their life.
5. Please describe their exact relationship to you. For example list your uncle as your mother's brother (MB) or father's brother (FB). List your grandmother as your mother's mother (MM) or father's mother (FM). And so on. Abbreviate using M for mother, F for father, B for brother and S for sister. If filling this out for your child list all relationships from the child's perspective not yours.
6. Make you mention all parents, grandparents, great-grandparents, aunts, uncles, great aunts and uncles, siblings and children whom you know the health history of.

Mother _____

_____

Mother's Mother _____

_____

Mother's Father_____

_____

Mothers Other Relatives (e.g. her brother = MB, her aunt = MFS or MMS)

_____

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_____

_____

Father _____

Father's Mother _____

Father's Father _____

Fathers Other Relatives _____

Brothers/Sisters _____

Children _____

# Classical Homeopathy, Inc.
# Physical History Form

To the best of your memory please fill in what serious physical problems or reoccurring minor physical problems you have had in your life in age order. Also please list any long lasting bad reactions to drugs. Also list any reactions to vaccines. Don't give any details just what the problems were. Example: Age 2- Chicken Pox; Age 3-5 Ear Infections; Age 4 - Fever after DTP vaccination; Age 12-16 Pains on Calves; Age 20-25 Migraine Headaches etc.

Age Problem

# Current Medicines Taken

Please list each medicine that you are currently taking. Include doctor prescribed drugs, over the counter medications, vitamins, herbs, homeopathics, other natural drugs and recreational drugs.

| Name | Purpose | Date Started | Dose | Frequency | Leave Blank | Leave Blank |
|---|---|---|---|---|---|---|
| Examples: | | | | | | |
| Tegratol | Anticonvulsant | 6/92 | 100 mg | 2 X day | | |
| Vitamin C | Nutrition | 2/89 | 500 mcg | Daily | | |

Email And Print | Print | Save as | Reset Form