MONTCLAIR HOMEOPATHY LLC
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PEDIATRIC REGISTRATION FORM

Referred by:

Name Nickname Birth date

Mother's Name and Address: Father's Name and Address:

Home #: Work #: Home #: Work #:

Occupation: Occupation:

Members of Household:

Name	Age	Relationship

Name of school or day care

Place of birth: Home Hospital

Birth weight:

Drug allergies or reactions to medications:

Check the relevant box if the child's mother had any of these problems during her pregnancy with this child:

- ❑ High blood pressure
- ❑ Diabetes or sugar in urine
- ❑ Albumin or protein in urine
- ❑ Urinary infection
- ❑ German Measles (3-day)
- ❑ Gonorrhea or Syphilis
- ❑ Drug or drinking dependence
- ❑ Frequent cigarettes
- ❑ Other problems or treatment or illness: explain
- ❑ Was this child born premature?
- ❑ Was the birth difficult?
- ❑ Was the baby born with forceps, cesarean, breech? (circle)
- ❑ Did the baby need help to start breathing or other problems?
- ❑ Did the baby remain in the hospital longer than the mother?
- ❑ Was this baby breastfed? To what age?

Has this child ever had the following problems:

- ❑ Asthma
- ❑ Chicken pox
- ❑ Croup
- ❑ Frequent bronchitis
- ❑ Hospitalization or operations
- ❑ Eczema
- ❑ Rheumatic fever
- ❑ Whooping cough
- ❑ Blood disorders (anemia, etc.)
- ❑ Convulsions or fits
- ❑ Pneumonia
- ❑ German measles (3-day)
- ❑ Mumps
- ❑ Scarlet fever
- ❑ Worms

Please check the immunizations this child has had:

- ❑ DPT (diphtheria, pertussis, tetanus)
- ❑ Mumps
- ❑ Measles
- ❑ Tetanus
- ❑ Rubella
- ❑ Hepatitis
- ❑ Small Pox
- ❑ Polio
- ❑ HIB
- ❑ Other

If your child has ever been bothered with any of the following problems check the box

- [ ] Frequent headaches
- [ ] Eye irritation
- [ ] Eyes crossing
- [ ] Trouble with vision
- [ ] Wears glasses
- [ ] Earaches or runny ears
- [ ] Difficulty hearing
- [ ] Pulling or tugging of ears
- [ ] Speech impediment
- [ ] Dental problems
- [ ] Sore or bleeding mouth or gums
- [ ] Bruises or bleeding problems
- [ ] Frequent colds
- [ ] Mouth breathing
- [ ] Recurring nosebleeds
- [ ] Recent sore throat
- [ ] Hoarse voice
- [ ] Wheezing or gasping
- [ ] Coughing spells
- [ ] Shortness of breath while walking or playing
- [ ] Must squat or hunch down often while playing
- [ ] Chest pains
- [ ] Burping or gas
- [ ] Abdominal pain
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Itching at anus
- [ ] Blood with stools
- [ ] Must have a special diet
- [ ] Frequent urination
- [ ] Pain or crying when urinating
- [ ] Brown black or bloody urine
- [ ] Bedwetting (> 4 years old)
- [ ] Daytime wetting (> 3 years old)
- [ ] Discharge from penis or vagina
- [ ] Marked increase/ decrease in appetite
- [ ] Weight loss or gain
- [ ] Rashes or swellings after eating certain foods
- [ ] Hay fever or allergies in spring, to animals, etc.
- [ ] Skin rashes or swellings
- [ ] Itching skin
- [ ] Warts
- [ ] Accidental poisoning
- [ ] Listless or tired
- [ ] Recurrent fevers
- [ ] Motion sickness
- [ ] Serious accidents, sprains, broken bones
- [ ] Shyness
- [ ] Frequent nightmares
- [ ] Waking often during night
- [ ] Fears
- [ ] Overly clinging
- [ ] Easily upset, crying
- [ ] Temper fits
- [ ] Breaks or throws things
- [ ] Fighting
- [ ] Stealing
- [ ] Lying
- [ ] Nervous or nervous habits
- [ ] Special school or classes
- [ ] Problems at school
- [ ] Problems with the family

Place an (x) in the appropriate columns for any illnesses that this child's blood relatives have had

	Allergies	Anemia	Arthritis/ Gout	Asthma	Bleeding/ Bruising Problems	Cancer or Tumors	Convulsios Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Heart Trouble	Hepatitis	High Blood Pressure	Frequent Infections
Father															
Mother															
Brother/Sister															
Grandparents:															
Maternal															
Paternal															

	Kidney/ Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostrate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problem
Father																
Mother																
Brother/ Sisters:																
Grandparents																
Maternal																
Paternal																

CONSENT FOR TREATMENT – FINANCIAL AGREEMENT: By signing this document, I hereby authorize Dr Corenthal Robins to treat my child using homeopathic medicines according to the principles of homeopathic practice. I understand and acknowledge Dr Corenthal Robins will base her treatment decisions on the school of homeopathic practice and that if I desire my child to be treated according to the traditional or allopathic school of medicine, I am free to seek such treatment form another physician, In some cases, it may be encouraged or required to do so. I understand Dr Corenthal Robins will make the best effort to treat my child, but makes no guarantees that her homeopathic treatment will cure my child. I also authorize Dr Corenthal Robins to video tape the interviews for the use of inter staff consultation on my child's case and /or for the use of teaching students of homeopathy.
I certify that the above information is true and give Dr Corenthal Robins permission to contact previous physicians. I understand that appropriate charges will be made and hereby agree that I am financially responsible for any such charges.

Signature of Parent/Guardian Date