Print and fill the forms: fax, email or mail to our office before you make an appointment.
Please bring this form on your appointment day.

Ph: (760) 245-2890 Fax: (760) 994-1374
www.homeopathyphysician.com email homeopathicdrpal@yahoo.com

Pediatric History Form

Personal History **Date -**______________

Name: ________________________________Gender_________ Date of Birth____/____/______(mm/dd/yyyy)
Age_______________ Birthplace____________________________(City & Country) Height __________inches
Parents Name ____ Weight________(lbs or Kg)
Are Parents (circle one) Married / Single / Divorced / Living together

Preferred Language for consultation –1st___________________2nd__________________(English, Hindi, Urdu, Punjabi)

Pregnancy and Birth

1. Problems during Pregnancy____
2. Substances used during Pregnancy Tobacco packs/day_____________ Alcohol__________ Drugs___________
3. Was your baby born early ?_____How early ?__________Was your baby overdue?_____ How early ?______
4. Complications of labor/delivery____
5. Birth Vaginal____________ C-Section______________ Epidural ______________ Forceps_________________
6. Problems during nursery stay____

Child and Family History
Illnesses – Mark (X) if your child or any family member (parents, siblings, grandparents, aunts, uncles) have had any of the following.

Illness	Child	Family	Illness	Child	Family
Frequent ear infections			Anemia/ blood disorders		
Hearing problems			Poor appetite/constipation		
Frequent cold/ sore throat			Diabetes		
Dental problems			Thyroid problem		
Croup			Kidney/ bladder problem		
Wheezing/ Asthma			Sexually transmitted disease		
Pneumonia			Bones/ Muscle problems		
Lung disease/ Tuberculosis			Seizures/ convulsions		
Hay fever/ allergies			Emotional disorder/ depression		
Heart murmur			Developmental delay problems		
High blood pressure			Bedwetting		
High Cholesterol			Skin disease		
Attention deficiency			Cancer		
Genetic disorders			Other illnesses		

Allergies: List any allergies including reactions to food, pollens, drugs, insects, animals, climate___________

____

Other Symptoms ____

Hospitalization/ Injuries/ Surgeries

Date	Illness/ Injury/ Surgery	Hospital/ Physician Name	City, State

Development and Behavior (mark (x) and explain)

	Yes	No	Explain
Did your child sit alone by 7 months?			
Did your child walk alone by 14 months?			
Did your child say 3 words by 15 months?			
Does he/she seem to get along well with others?			
Seems easy to handle?			
Have trouble changing activities?			
Receive any special services?			
Experience nightmares?			
Have sleep problems?			
Have discipline problems?			
Have bad temper?			
Holds his/her breath?			
Have temper tantrums?			
Have toilet training problems?			
Have problems with bedwetting?			
Have speech problems?			
Attend school?			What grade?

Health and Safety Issues	Yes	No
1. Is the child having any access to guns or drugs?		
2. Is there a working smoke alarm in your house?		
3. Was your house or apartment built before 1965?		
4. Is the hot water temperature less more than 125 F?		
5. Are all medicines and poisons kept out of reach from child?		
6. Does your child use a car seat or seat belt all the time?		
7. Does your child wear a bicycle helmet all the time when riding bicycle?		
8. Do you have rules/limits for television viewing/computer games?		
9. Is your child exposed to secondary cigarette smoke/fumes from wood/kerosene heaters?		
10. Does the child live with any adult having alcohol or drug problem?		
11. Does the child eat home made food most of the time?		
12. Any other issue not mentioned and you want to update during consultation.		

Age at 1st DTaP Immunization _______________

Immediately following 1st Immunization any adverse effects observed or treated (like seizures, hives, eczema, Meningitis, Pneumonia, Sepsis etc) ____

Immunization Record – (Please Fill or attach immunization record)

	1	2	3	4	5	6
	Date	Date	Date	Date	Date	Date
DTaP						
IPV						
Hepatitis B						
PCV						
HIB						
Rota						
Flu Shots						
Other						

Copies of lab reports should be sent with this form

Pictures should be sent with the pediatric form (Virtual Consultation only)

Mailing Address -- **PAL**
14534 GRAHAM AVE
VICTORVILLE, CA
USA 92394

This history record has been designed to facilitate our patients to assess their health issues in detail.

Once Homeopath Pal reviews this history record and reports he will be asking you specific questions pertaining to your symptoms to get a complete disease picture. *Each symptom will be completed regarding its location, extension, sensation, modalities and concomitants during the* virtual or in office consultation process.
A complete case record thus created will be analyzed for a Homeopathic prescription. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.

____

Date Patient/ Guardian signature that filled out the history

Mailing Address

____

____

Phone – Home -- __________________________

Cell -- __________________________

Email -- __________________________

For more information visit www.homeopathyphysician.com see virtual consultation tutorial

Authorization for the release of Medical Records

Patient Name ______________________ Today's Date ______________

Patient SSN ______________________ Date of Birth ______________

Person(s), Class of Persons or Organization to Release Information to Singh S Pal.

Name ______________________ Mailing Address ______________________

City __________ State ______ Zip ______ Phone # ______________ Fax# ______________

Singh S Pal Office to receive information at: 14359 Amargosa Rd Ste T, Victorville CA 92392
Ph (760) 245-2890 Fax (760) 994-1374 email homeopathicdrpal@yahoo.com

Description and Purpose of the Information to be released:

____

Expiration Date or Related event that will cause Authorization to expire:___________________________
(If no expiration date is specified, this authorization will expire one (1) year from the date it was signed).

By signing this form, I authorize the release of protected health information about me (or another person for whom I have authority to sign) to Singh S Pal for the time period, purpose, and extent described above. My signature indicates that I fully understand and acknowledge the following:

• My health record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, blood alcohol and drug testing, and treatment for alcohol and drug abuse.

• The protected health information to be used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal law.

• I have the right to refuse to sign this authorization. CPC will not condition treatment, payment, enrollment, or benefits eligibility on my signing this authorization.

• I have the right to revoke this authorization in writing at any time to the extent that the use or disclosure has not already been made. I may do so in person at the office where my records are maintained.

Signature of Patient or Authorized Representative ______________________ Date ______________

Name of Patient or Authorized Representative (please print) ______________________ Relationship to Patient (please print) ______________

Homeopathic Practitioner Singh S Pal, D.H.M.S. *(Diploma in Homeopathic Medicine Surgery & Midwifery)*

Practitioner Disclosure & Client Consent Form

Welcome to my Holistic Homeopathic practice. As per the requirements of the Senate Bill 577 it is informed that I am not a licensed physician nor the Homeopathic services licensed by the state. This mode of treatment is alternative or complimentary to the healing arts services licensed by the state.

Homeopathic system of treatment consider person as a whole entity with his mental, physical and emotional symptoms. It does not put a diagnosis label on the person. When Homeopathic case taking is done, it contains complete details of every symptom regarding its causation, location, duration, sensation, extension, modalities, concomitants including any peculiar or keynote symptoms. Past ailments and family history are also considered while prescribing. It is called as symptom totality.

The symptom totality is then matched with the drug picture. Closest/ perfect match – faster the recovery. Computerized system helps in matching the drug picture to the symptom totality, which is second important step after case taking. Last but not the least counts the professional capability and experience in Homeopathic system of medicine which helps the individual to recover and regain healthy state. Homeopathic treatment helps increase immunity of the body.

Education, Training and Experience – *I did my D.H.M.S (Diploma in Homeopathic Medicine Surgery & Midwifery) a 4 years full time course with 24 core/elective clinical rotations at General Hospital Chandigarh and 6 months clinical internship from Homeopathic Medical College Chandigarh, India. I was registered as a Homeopathic Doctor in states of Punjab, Haryana and Chandigarh INDIA. I am practicing Holistic Homeopathy for the last 25 years.*

In order to use my services, California State requires that you acknowledge receipt of the information provided in this form by signing it. You will receive a copy. I will keep the original in my record for three years. I will provide Homeopathic therapy, subject to requirements and restrictions of Senate bill 577. If you have any concerns about the nature of your treatment, please feel free to discuss with me. Please remember that doctors, nutritionists, herbalists, and other medical professionals and health practitioners hold widely varying views. I intend to offer health information to help you cooperate with a competent medical doctor (MD) in your mutual quest for health. I recommend that you inform your medical doctor that you are receiving Homeopathic treatment.

Acknowledgement and Consent to receive services

I have read and understood the above disclosure about the Homeopathic therapy offered by Singh S Pal and his training and education. I have discussed about the nature of treatment to be provided. I understand that he is not a licensed physician and that his services are not licensed by the state. I understand my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered and agree to be personally responsible for the fees in connection with the services he provide me.

Name:____ (Minor)

Signed: ____ Date:____________________________

Self/ Parent/ Guardian: ____(Print name)

Appointment Cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

How to Cancel Your Appointment

In order to be respectful of the needs of all patients, if it is necessary to cancel your reserved appointment we require that you contact our office by 10:00am one (1) working day in advance. Appointments are in for convenience and availability and your early cancellation will give another person the possibility to access timely homeopathic consultation.

To cancel an appointment, please call (760) 245-2890 to speak with an office representative. If you do not reach an office representative, you may leave a detailed message on the office voicemail. You may not cancel a scheduled appointment via email.

No Show Policy

A ‘no show’ appointment occurs when a patient misses an appointment without canceling by 10:00 A.M. one (1) working day in advance. No show inconveniences patients who need access to homeopathic care in a timely manner. **Last minute/late cancellations are considered ‘no show’ appointments.**

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a ‘no show’. The first ‘no show’ will result in a **$25** fee being applied to your account, as well as an email or a letter being sent to your home alerting you that an appointment was missed without canceling. If there is a second ‘no show’ a **$50** fee will be billed to your account and a second email/letter will be sent. A third ‘no show’ will result in suspension of services and dismissal from our homeopathic office.
Exceptions to this policy must be approved by the Office Manager.

By signing below I certify that I have read and understand the terms and conditions of Homeopathic Office appointment cancellation policy:

Authorization: I___________________________________ authorize Pal Homeopathy to Charge my credit

card No._______________________________________ expires__________________ CVV___________

for all applicable no show fee.

X____

Patient/Parent/Guardian Signature Date