Lotus Wellspring Healthcare/ Sybil Ihrig, CCH, DACM, L.Ac.
44650 Village Court, Suite 100, Palm Desert, California 92260
Phone: 760-854-4242; email: lotuswellspring@gmail.com ; web: www.lotuswellspring.com

Registration Form (Child) Please Print

Name: _____ Birth date: _____
Height _____ Current Weight: _____
Home Address: _____ Home Phone: _____
_____ Cell Phone: _____
City, State, Zip: _____ Parent's Email:

Gender		Parent's Marital Status				# of Siblings
Male	Female	Single	Married	Divorced	Widowed	
☐	☐	☐	☐	☐	☐	

Home Address: _____
City, State, Zip: _____ Home Phone: ( )_____

Mother's Name: _____ Work or Cell Phone: ( )_____
Mother's Employer: _____
Business/Work Address: _____
Father's Name: _____ Work or Cell Phone: ( )_____
Father's Employer: _____
Business/Work Address: _____
Person to be contacted in case of emergency: _____
Address: _____
_____ Phone #: ( )_____

Please indicate briefly the main problem for consulting a homeopath: _____
_____
_____

Please provide the following information starting with the most recent. Include type of illness, month and year hospitalized, name of hospital, city and state.
1. _____
2. _____
3. _____

Please list any medication you are taking (type, dosage, frequency …)_____
_____

Medicinal Herbs, Vitamins, Teas:_____
Allergies:_____

Medical Tests	Year	Immunizations	Year
Chest X-ray		Small Pox	
Electrocardiogram		Tetanus	
TB Test		Polio	
GI Series		Typhoid	
Kidney X-ray		Mumps, Measles	
Barium Enema		Flu	
Other X-ray		Other	

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Child Registration Form continued (Please Print)

What are you most sensitive to (example: Noise, odors, light, pain …)? _____

Describe an ideal day in terms of weather and temperature: _____

What are your fears? _____

Do you have any hobbies? _____

(**This question teenage girls only**) What symptoms do you experience premenstrually? _____

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: _____

How is your energy? Is there any particular time of day when it is lower or higher? _____

How is your sexual interest/drive? _____

What do you most like to eat or crave? _____

What foods do you most dislike? _____

How is your thirst? _____

What temperature do you like fluids? _____

Are there any foods that you are sensitive to or allergic to? _____

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Child Registration Form Continued…

Please place a check mark " ✓ " for any of these that apply

✓	Problem	✓	Problem	✓	Problem
	Frequent/severe headaches		Aching muscles or joints		Frequent belching
	Back pains		Swollen joints		Nausea
	Neck lumps or swelling		Back or shoulder pains		Vomiting
	Loss of balance		Weakness in arms/legs		Pain in abdomen
	Dizzy spells		Painful feet		Bloated abdomen
	Blackouts/fainting		Trembling		Constipation
	Wear glasses/contacts		Numbness		Loose bowels
	Blurry vision		Leg cramps		Black stools
	Eyesight worsening		Skin problems		Grey or whitish stools
	See double		Scalp problems		Pain in rectum
	See halos or lights		Itching or burning skin		Itching rectum
	Watering eyes		Bruise easily		Blood with stools
	Earaches		Nervousness or anxiety		Frequent urination
	Hearing Difficulties		Nervous with strangers		Involuntary urination
	Runniny ears		Nail biting		Burning on urination
	Noises in ears		Difficulty making decisions		Black or bloody urine
	Dental problems		Lack of concentration		Weak urine stream
	Sore or bleeding gums		Loss of memory		Difficulty starting urine
	Sore tongue		Lonely or depressed		Constant urge to urinate
	Congested nose		Frequent crying		
	Running nose		Hopeless outlook		**Girls Only**
	Sneezing spells		Difficulty relaxing		Missed period
	Head colds		Worry a lot		Menstrual problems
	Nosebleeds		Scary dreams or thoughts		Bleeding between periods
	Sore throat		Feeling of desperation		Heavy bleeding
	Difficulty swallowing		Shy or sensitive		Bearing down feeling
	Hoarse voice		Dislike criticism		Vaginal discharge
	Wheezing or gasping		Angered easily		Genital irritation
	Frequent coughing		Annoyed by little things		Pain on intercourse
	Cough up phlegm		Family problems		Swelling of breasts
	Cough up blood		Problems at work		Painful breasts
	Chest colds		Sexual difficulties		
	Rapid or skipped heart beats		Change of sexual energy		# of pregnancies
	Chest pains		Considered suicide		# of births
	Shortness of breath		Loss or gain in weight		# of miscarriages
	Swollen feet or ankles		Loss of appetite		# of premature births
	Armpits or groin swelling		Always hungry		# of caesareans
	Difficulty sleeping		Fatigue or weariness		# of abortions
	Motion Sickness		Fever or chills		
	Excessive sweating		Motion sickness		**Boys Only**
	Recurring indigestion		Night sweats		Burning of discharge
	Sexually transmitted diseases		Hot flashes		Swelling on testicles
	Are you ticklish		Warm/colder than others		Painful testicles

Comments or special problems:

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Child Registration Form - Family History <<>> Please Place an X in the appropriate column for any illness that you or your relatives have had

Illness	Self	Father	Mother	Brothers	Sisters	Child #1	Child #2	Child #3	Grandparents
Abnormal Periods									
Alcohol/Drugs									
Allergies									
Anemia									
Arthritis/Gout									
Asthma									
Bleeding problems									
Cancer									
Diabetes									
Eczema									
Emphysema									
Epilepsy									
Frequent Infections									
Heart Trouble									
Hepatitis									
High Blood pressure									
Kidney problems									
Mental Illness									
Migraines									
Polio									
Pneumonia									
Prostate problems									
Psoriasis									
Rheumatic Fever									
Stomach problems									
Stroke									
Thyroid problems									
Tuberculosis									
Ulcers									
Venereal Disease									
Weight problems									

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Please use the space below to add any additional information you feel is important to convey. (For parents: If you experienced any specific traumas during the pregnancy or birth process, please provide details.)