

Avghi Constantinides D.Hom HMC MA

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Homeopath

Centre for life

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Personal Health Questionnaire for Child

All information will remain strictly confidential. Homeopathy helps balance the whole person on a physical, emotional and mental level. Please be as open and precise as you can. If your child is old enough have, him/her fill out the questionnaire or help them through it. For babies do the best you can and use your intuition, you know your child best.

Thank you for your trust and patience.

Please print clearly

Date: _____

Name: _____

DOB: / / **Age:** **Place of Birth:** _____

Address: _____

Phone: H() _____ **E-mail:** _____

Mother's name: _____

Cell Phone: () _____ **W()** _____

Father's Name: _____

Cell Phone: () _____ **W()** _____

Grade in School: _____

Pediatrician: _____ **Phone:** () _____

Height: _____ **Weight:** _____

Surgery: _____

Left/Right handed: _____

Siblings: _____ **Pets:** _____

Referred by: _____

Present/Current Complaint: _____

Pain, Where? _____

History & Past Treatment & Old Injuries: _____

Vaccinations

	Birth	1 M	2 M	4 M	6 M	12 M	15 M	19-23 M	2-3 Y	4-6 Y	7-10 Y	11-12 Y	13-18 Y
Vitamin K (At birth)													
Silver Nitrate drops (At birth)													
Hepatitis B (At birth on going series)													
Rotavirus (2, 4, or 6 months)													
Diphtheria, Tetanus, Pertussis DTAP (2,4,6 Months, 11, 13 Years)													
Pneumococcal (PCV) (2,4,6 months)													
Polio (IPV) (2,6, Months & 6-18 Month range)													
Influenza (usually yearly)													
Measles, Mumps, Rubella MMR (12-15 Months, 4-6 Years)													
Haemophilus influenza type b Hib (2,4,6 months)													
Varicella (chickenpox) (12-15 months & 4-6 years)													
Hepatitis A (12-18 months, ongoing, series)													
Meningococcal MCV4 (3-6 years, 11 years)													
Human Papillomavirus HPV (3 doses- 11-13 Years)													

Reactions to Vaccines: _____

What Specific Events Have Impacted or Changed Your Life: _____

Family History Please list all ailments: (e.g. Cancer, TB, Asthma, Heart disease)

Personal History Circle where appropriate. Put * if you have this today

Accidents	Diabetes 1 (Diet)	Hepatitis	Night sweats
Addictions	Diabetes 2 (Insulin)	Herpes	Nose bleeds
ADD/ADHD	Drug overdose	High/Low blood pressure	Numbness
Alcoholism	Drug problem	HIV/AIDS	Panic attacks
Allergies	Dyslexia	Infections	Paranoia
Anemia	Endometriosis	Insomnia	Paralysis
Angina	Epilepsy	Jaundice	Physical abuse
Anorexia	Excessive eating	Kidney dysfunction	Pneumonia
Anxiety	Excessive fears	Liver dysfunction	Polio
Asthma	Flashes (hot/cold)	Low Libido	Rectal problems
Bi-Polar	Food poisoning	Manic depression	Ringing in ears
Boils	Fungus	Meningitis	Sexual abuse
Bulimia	Gall bladder	Mental disorder	Skin problems
Candida	Hay fever	Mono	Tingling
Chronic fatigue	Head injuries	Nervous	Ulcers
Convulsions	Headaches	Nightmares	Verbal abuse
Depression	Heart disease		Vertigo
			Warts

Medication Circle where appropriate put an * if you are on them today

Anti-biotic	Heart	Radiation
Anti-inflammatory	Herbs	Relaxants
Anti-histamines	Laxatives	Sleeping pills
Antidepressant	Lithium	Street Drugs
Aspirin/Tylenol	Oral Contraceptives	Supplements
Chemotherapy	Thyroid	Vitamins
Cortisone	Over The Counter	

Other _____
Duration _____ How often _____

What age did your child walk: _____
What age did your child talk: _____
What age did the fontanel close? _____

Mother's Only

How many Pregnancies? _____ Number of births? _____
Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs? _____
Specify _____
Abnormal bleeding during pregnancy? _____
Miscarriage: _____
C-Section: _____
Complications during Pregnancy? _____
Which Pregnancy? _____
Complications during Labor? _____
Which Labor? _____
How much alcohol do you drink? _____
Do you take medication? _____
What were your emotions at time of conception? _____

What were your emotions during the pregnancy? _____

Father's Only

Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs?
Specify _____

What were your emotions at time of conception? _____

What were your emotions during the pregnancy? _____

Did you have any complications during your wife's pregnancy? _____

How much alcohol do you drink? _____
Do you take medication? _____

EMOTIONS To the best of your ability help your child fill this page out, with infants go with your instinct. Indicate with numbers: 1 being mildest -1 2 3 4 5- 5 being strongest If it does not apply then leave blank

- | | | |
|--------------|------------------|-----------------------|
| Affectionate | Grief | Restless |
| Ambitious | Guilty | Righteous |
| Angry | Hold in Feelings | Sadness |
| Anxious | Hurried | Secretive |
| Assertive | Impatient | Self-esteem |
| Bossy | Independent | Self-pitying |
| Cautious | Insecure | Sensitive |
| Closed | Jealous | Sentimental |
| Confidence | Lonely | Serious |
| Courageous | Loss | Sexual |
| Critical | Love music | Spiritual |
| Death | Loving | Stubborn |
| Depressed | Motivated | Swearing |
| Discontented | Need company | Talkative |
| Disorganized | Needy | Tense |
| Distrust | Non assertive | Thrifty |
| Dogmatic | Observant | Tidy |
| Dullness | Optimistic | Trouble concentrating |
| Easily Hurt | Organized | Unaffectionate |
| Excitable | Panic attacks | Unemotional |
| Fanatical | Pessimistic | Unforgiving |
| Fastidious | Poor memory | Uninterested |
| Fearful | Procrastinate | Violent |
| Flirtatious | Regretful | Weepy |
| Forceful | Religious | Workaholic |
| Forgetful | Resentful | Worried |
| Generous | | |

- | | | | |
|------------------------------|-------|------------------------|-------|
| Prefer outdoors/ indoors? | _____ | Favorite season? | _____ |
| Tolerate temperature change? | _____ | Favorite color? | _____ |
| Food desires? | _____ | Drinks desires? | _____ |
| Food aversions? | _____ | Drinks aversions? | _____ |
| Like solitude/company? | _____ | Like touch from others | _____ |
| Like attention when unwell? | _____ | Sleep position? | _____ |

Hobbies/sports _____

I..... State all information given above is to the best knowledge, all true and correct. I understand Avghi Constantinides D.Hom HMC MA is not a medical doctor and homeopathy is not state licensed in California. (There is no License in the State of California see SB577)

Signed.....Date.....



Patient disclosure: Please read carefully!

Welcome to my practice. As you know, I am a practitioner of homeopathy. I am not a licensed physician, nor are homeopathic services licensed by the state. The idea behind homeopathy is that it is a natural system of energetic medicine that uses specially prepared (FDA regulated since 1938) highly diluted doses of substances to stimulate the body's own healing mechanism. As a practitioner of homeopathy, I will provide you with the following kinds of services:

Initial homeopathic consultation, Selection of a homeopathic remedy and Follow-up consultations to evaluate treatment response.

I have been practicing **homeopathy** since **1995**. My training and education is described below:

I hold Bachelors of Science in Nutrition, a Masters Degree in Homeopathy, Advanced Clinical Homeopathy, a Diploma in Homeopathy and a Homeopathic Master Clinician. I have studied with some of the most renowned prominent homeopaths in the world, and my education is always on going. I am a member of National Center of Homeopathy & the North American Society of Homeopaths. I am the Co-Founder and Director of Los Angeles School of Homeopathy and the founder and director of Centre for life, Integrative healing center.

In order to use my services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. I will keep the original in my records for at least three years.

My method of treatment is **homeopathy**, its alternative or complementary to healing arts that are licensed by the State of California. Under Sections 2053.5 and 2053.6 of California's Business and Professions Code, I can offer you these services, subject to requirements and restrictions that are described fully on the page below.

If you have any concerns about the nature of your treatment, please feel free to discuss them with me. I recommend that you inform your medical doctor that you are receiving **homeopathic** treatment.

Acknowledgement and Consent to Receive Services:

I have read and understand the above disclosure about the **homeopathic** treatment offered by **Avghi Constantinides** and **Avghi Constantinides'** training and education. I have discussed with **Avghi Constantinides** the nature of the services to be provided. I understand that she is not a licensed physician and that **Avghi Constantinides** services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered by **Avghi Constantinides**, and agree to be personally responsible for the fees of **Avghi Constantinides** in connection with the services provided to me. I understand the office policies and cancellation policies and phone fees.

Signed: _____

Date: _____

Print name: _____

Indicate capacity to sign if other than client _____ (Client/parent/conservator/guardian)

I understand and agree to all parts of this document.

**CALIFORNIA SENATE BILL SB-577
WHAT IT MEANS FOR PATIENTS**

California Senate Bill SB-577, which was signed by the governor in September 2002, has profound implications for the practice of alternative forms of health care in California. SB-577 enables alternative and complementary health care practitioners to provide and advertise their services legally. However, they must also comply with certain requirements specified within the bill.

What does Senate Bill SB-577 mean for you, the patient?

SB-577 gives you access to alternative and complementary health care practitioners. You must be given information about the nature of treatment and the practitioner's qualifications. Feel free to ask a practitioner any question you might have about your treatment. Check to see if your practitioner has been certified by a professional membership society. In addition, tell your doctor about any alternative treatment you are pursuing. You can also request that your licensed and unlicensed health care providers communicate with each other and work collaboratively to meet your health care needs. **SB-577 helps to protect you.** SB-577 requires unlicensed alternative health care practitioners to follow certain guidelines and restrictions.

Here are the things that unlicensed alternative practitioners are NOT allowed to do:

- Perform any form of surgery or any procedure that punctures your skin or harmfully invades your body.
- Use X-ray radiation.
- Prescribe prescription drugs, or recommending that you discontinue drugs that were prescribed by a licensed physician.
- Set fractures.
- Treat wounds with electrotherapy.
- Put you at risk of great bodily harm, serious physical or mental illness, or death.
- Imply in any way that they are licensed physicians.

In addition, an unlicensed alternative practitioner MUST DO the following things:

- Provide you with a statement, written in plain language that includes the following information:
 - (1) That they are not a licensed physician and that their services are not licensed by the state;
 - (2) A brief and clear description of the kind of services they provide and the reasoning behind it;
 - (3) A description of their education, training, and experience.
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Fees, Office Policy and directions

- **Remember to bring your form filled out.**
- **Fees and Cancellation Policy:** At the time of booking your initial appointment, a credit card will be necessary to hold your appointment. New patient appointments can be changed or cancelled at no charge before 48 hours of your appointment, after the **48 hour required notice** your credit card will be charged for the missed appointment, the fee is the same as the appointment fee. The same applies to follow up appointments. Please call if you can't make the follow up appointment. There is a charge (same as appointment fee) which will be billed to your credit card on file for cancellations made within 48 hours of the appointment. I book appointments just one person at a time. Your time is valuable to me. Please be courteous, if you can't make an appointment and give me 48 hours notice.
- **First consultation is \$355 will last between 60-90 minutes** give yourself plenty of time to get here, park and find the office the first time. **Follow-ups are \$135 will last 30 minutes. If you need a consultation in-between, phone consultations are \$45 for each 15 minutes. If you have not been seen in a year your appointment will be \$175 for 45 minutes.** Follow-ups are usually 4-6 weeks apart. Checks, Visa, Master Card or Cash accepted.
- **Directions** From the 405 exit 90 freeway west, turn Right onto Lincoln which is at end of Freeway, Right on Washington Blvd, the building is on the Left side between Walgrove Ave & Redwood Ave. It's a beautiful Victorian Building. This area is also known as Marina del Rey adjacent. OR from the 405-exit Venice Blvd, towards the ocean, turn left on Walgrove & Left on Washington and we are on the left hand side of the street.
- The Building is located 4 blocks East of Lincoln, near Costco, On the North Side of the street on Washington Blvd.
- **Parking:** is on the street, some metered some not. There is also parking on Redwood and Walgrove. Please read posted signs.
- **Office:** At front door please buzz "**Centre for Life**". Take the elevator to the second floor, suite 202

Thank you.