

Avghi Constantinides D.Hom HMC MA

(424) 501 6193

avghi@homeopathyforlife.com



Homeopathy For Life

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: M/D/Y

Age:

Place of Birth:

Gender Identity: M or F **Assigned at Birth:** M or F **Preferred Pronouns:**

Address:

Phone:

Mother's name

Father's Name:

Grade in School:

Pediatrician:

Height

Surgery:

Left/Right handed:

Siblings:

Referred by:

E-mail:

Phone

Phone

Phone:

Weight:

Pets:

Please describe your present/current chief complaint: How and when it began and how it has progressed. Describe the nature of the symptoms, in particular the sensations experienced and anything which make the symptoms better or worse or other symptoms which occur at the same time.

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: Please write as much as you can in description, the nature in terms of personality and behavior describe anything which helps to characterize you.

What Specific Events Have Impacted or Changed Your Life:

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

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

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

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

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.....



Office Policies

California Senate Bill SB-577, 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 non-licensed 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 client?

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 non-licensed 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 non-licensed alternative health care practitioners to follow certain guidelines and restrictions. Here are the things that non-licensed 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, non-licensed 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.

Client disclosure: Please read carefully!

Welcome to my practice, I am a practitioner of homeopathy, I am not a licensed physician, nor are homeopathic services license by the state of CA. The idea behind homeopathy is that it is a natural system of 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 followings 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 have a Bachelors of Science in Nutrition, Masters Degree in Homeopathy, Diploma in Homeopathy, Homeopathic Master Clinician, Royal Society of Homeopaths in North America, International Homeopathic Certification. I have studied with world renowned prominent homeopaths, my education continues each year with at least 2 weekend seminars annually. I teach Homeopathy, give talks to the community about Homeopathy. I am a member of National Center of Homeopathy, North American Society of Homeopaths, Association for International Homeopaths and the President of North American Network of Homeopathic Educators. Co-Founder and Director of Los Angeles School of Homeopathy, founder and director of Centre for Life, Integrative healing center, and founder Homeopathy for Life.

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**, a complementary healing art, in 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 this document.

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.

Fees, Office Policy and directions

- **Remember to bring your form filled out or emailed ahead of your appointment time.**
- **At the time of booking your initial appointment**, a credit card will be necessary to hold your appointment. Your card will be charged at the time of your appointment and not before. You can also pay via Venmo or Zelle, if arranged at the time of the appointment, payments are due at the time of service. If we ship you any remedies or order them on your behalf, we will charge you for those.
- **Cancellation policy:** Our office requires a 48-hour notification, your appointment 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.
- **Missed appointments:** If you miss an appointment and cancel less than 48-hours notice, your card will be charged for the same amount of the missed appointment. Please call if you can't make the follow up appointment before 48-hours.
- **Payments:** By signing below you agree to have your card on file and charged for any serviced rendered.
- **Credit card information:** Patients will be responsible for updating the credit card on file as needed throughout treatment.

- **Time:** 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, please give me 48-hours notice, otherwise there is a charge for the missed appointment, which is the same as the fee.
- **Payment:** The fee for your consultation is due at the time services are provided and will be charged accordingly.
- **First consult \$455 will last between 60-90 minutes** . If in-person appointment, give yourself time to get here, park and find the office the first time. If online appointment, just click on the link sent to you in your appointment reminder.
- **Follow-up consult \$135 will last 30 minutes.** Follow-ups are usually 4-6 weeks apart.
- **Phone/email consults:** If you need an acute consult in-between, the fee is \$45 for each 10 minutes. This is not for follow up consults. If a difficult acute Avghi may need more than 10 minutes to do research.
- **Returning:** If you have not been seen in a year your appointment will be \$175 for 45 minutes.
- **Remedies:** Most remedies are between \$7-\$30, shipping is around \$7.
- **Payment methods:** Visa, Master Card, Venmo, Zelle or Cash

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 or her office staff** 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 of California. 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, cancellation policies and phone/email consult fees. Any controversy or claim arising out of, or relating to, this agreement, first need to be addressed with Avghi and her office staff, if that issue was not settled by the office, then it shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction. The patient will pay for the arbitration fees.

Signed: _____ Date: _____

Print name: _____

Indicate capacity to sign if other than client _____

(Client/parent/conservator/guardian)

up dated 3.10.2023 Thank you.