



**JENNIFER SILVA**  
**Classical and Modern Homeopathy**  
**6682 Alexandria Drive, Huntington Beach CA 92647**  
**714-614-7089, jensisilva809@gmail.com**

**Developmental and Behavioral Concerns Intake Form**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Present Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Blood group if known: \_\_\_\_\_

Father and Mother Names: \_\_\_\_\_

Cell and Email: \_\_\_\_\_

Child's Primary Address: \_\_\_\_\_

General Description of why you are seeking help for your child: \_\_\_\_\_

\_\_\_\_\_

When did you first sense that something felt different? Was there any precursor? E.g. traumatic event, sickness, vaccination: \_\_\_\_\_

\_\_\_\_\_

Sleeping patterns (Is going to bed difficult? In what ways? Are there any night terrors? How many hours of sleep does the child get on average each night?): \_\_\_\_\_

\_\_\_\_\_

Is the child in school / day care / homeschool? \_\_\_\_\_ What grade? \_\_\_\_\_

Who does the child live with? (Include parents, siblings, their ages and pets) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Eating habits: \_\_\_\_\_

Food preferences: \_\_\_\_\_

Overall health of the child (Please include physical symptoms, susceptibilities, complaints) \_\_\_\_\_

\_\_\_\_\_

Has your child been formally diagnosed? If so with what? \_\_\_\_\_

\_\_\_\_\_

Behavioral concern #1: \_\_\_\_\_



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Behavioral concern #2: \_\_\_\_\_

Behavioral concern #3: \_\_\_\_\_

Describe mother's pregnancy. (Please include any medications used or vaccinations taken): \_\_\_\_\_

Describe the birth experience. (Please include any medications used. Was the labor induced?  
How long did the labor last? Was there a C-section?) \_\_\_\_\_

Was baby breast fed? Any troubles latching \_\_\_\_\_

At what month did the child: Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Eat independently \_\_\_\_\_

Use first words \_\_\_\_\_. Has there ever been any regression of milestones at any time? If so when  
did the regression occur? \_\_\_\_\_

Brief description of health of the parents: Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Describe the child's living situation. Please list any known stressors \_\_\_\_\_

Describe your child. What does he or she like to do? \_\_\_\_\_

Child's Personality: \_\_\_\_\_

Child Strengths: \_\_\_\_\_

Child's Weaknesses: \_\_\_\_\_

Current supplements, vitamins, and medications the child takes: \_\_\_\_\_

Additional Comments \_\_\_\_\_



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Dear parent/guardian,

*Welcome to my practice. This questionnaire will help me to understand and assess your child. I am the only person who will review this survey and your confidentiality is strictly maintained. The questionnaire is quite detailed, I don't expect you to remember every date, try to be close.*

*If you have questions or concerns about this questionnaire, please contact me and I will help you to decide how best to solve the issue.*

**FEE SCHEDULE**

**Initial consultations include a review of the intake form and other materials, research on your child's case and usually an initial care plan. Sometimes more information is required before I can design a comprehensive initial care plan.**

**Fee schedule is subject to change without notice.**

Initial consultation, 60 minutes	\$450.00
Extended follow-up, 60 minutes	\$240.00
Extended follow-up, 45 minutes	\$180.00
Regular follow-up, 30 minutes	\$120.00
Quick check-in, 15 minutes	\$65.00
Email consultations.....	minimum 15 minutes, \$65.00
NSF cheques.....	\$30.00
Medical - Legal reports.....	varies with amount of time spent
Failure to keep a scheduled appointment.....	cost of scheduled visit

All fees must be paid at the time of booking.

**Please note: Forms of payment accepted are check or Zelle.**

**ACKNOWLEDGMENT**

In order to avoid any confusion or misunderstanding, Jennifer Silva requests that all clients read and acknowledge the following:

That you understand that Jennifer Silva works within the homeopathic scope of practice, is not a medical doctor, and employs some methods which are not orthodox medical practice at this time, for example Pranic healing.

- That you understand that the services here and/or referral to other health professionals is based upon the assessment of health status revealed through personal history and interview, physical assessment and laboratory testing.
- That you understand that Jennifer Silva uses natural therapeutics for the support and correction of physical, mental or energetic imbalances, primarily homeopathy.
- That you understand that you are responsible for any fees incurred while under care.
- That you are here as a client and are not receiving Jennifer Silva's healing services for any other reason without making your intentions known to her.

**Please be informed that you are required to give at least 1 business days' notice in case you need to cancel or reschedule any appointment, including the initial one. I regret that otherwise you will be charged for the missed appointment.**

We greatly appreciate your consideration in this matter.

\_\_\_\_\_

\_\_\_\_\_

Date

Patient's/Guardian Signature



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## **Consent for Care**

Jennifer Silva will take a thorough case history, and may perform an examination related to your child's concerns if indicated.

It is very important that you inform Jennifer of any disease process that your child is suffering from and any supplements/medications/over the counter drugs that he or she is currently taking.

There are some health risks associated with the use of homeopathic remedies, herbs and supplements. These include but are not limited to the following:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Homeopathic remedies may stimulate healing or detoxification reactions, which may include loose stools, increased perspiration, skin eruptions and nasal discharges, among others. These reactions are uncommon and normally pass within a few hours to days.
- Herbal tinctures can taste bad and may occasionally cause headaches or stomach discomfort.
- Nutritional supplements sometimes cause stomach discomfort. Vitamins containing Niacin (B3) may cause temporary flushing and itching.
- Some people experience allergic reactions to certain supplements and herbs. Please advise Jennifer immediately if you think that your child has experienced an allergic reaction.
- Please let Jennifer know immediately should your child experience any negative side-effects from any homeopathic remedies, herbs or supplements.

Important points to note:

- **Jennifer Silva does not guarantee results.**
- A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law. You are entitled to a copy of your records at any time and to transfer of your records to another practitioner if desired, however, you will have to pay for the costs of copying and mailing the records.
- Jennifer will explain to you the exact nature of any care provided and will answer any questions you may have to the best of her ability.
- You are free to withdraw your consent and to discontinue care at any time.

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I certify that I have read and understood the above **Consent for Care**.

Patient Name: (Please print name): \_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for completing this survey. Please email back to [jensisilva809@gmail.com](mailto:jensisilva809@gmail.com)  
JENNIFER SILVA HOMEOPATHY