Homeopathy Heals

HOMEOPATHIC CONSULTATION – ADULT INTAKE FORM

PATIENT INFORMATION

NAME:_____AGE:_____DATE OF BIRTH:_____

ADDRESS:_____

HOME PHONE:_____WORK PHONE:_____

E-MAIL ADDRESS_____

MARITAL STATUS: S M D W SEP #CHILDREN:_____ AGES: _____

OCCUPATION:_____EMPLOYER:_____

PRIMARY CARE PHYSICIAN: _____

YOUR INFANCY

PROBLEMS DURING PREGNANCY	*PROBLEMS DURING LABOUR*	*BIRTHWEIGHT*

VACCINATIONS/CHILDHOOD ILLNESSES/STDs/INJURIES/SURGERIES

ANY ADVERSE EFFECTS FROM VACCINATIONS?	*PERSONAL HISTORY OF ANY SEXUALLY TRANSMITTED DISEASES?*	*INJURIES OR SURGERIES (+ COMPLICATIONS)*

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU

COMPLAINT	*SINCE*	*CAUSES*

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	*SINCE*	*ADVERSE EFFECTS*

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT OR REGIME	*SINCE*	*RESULTS*

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? (please circle all that apply)

Abscesses | AIDS/HIV| Alcoholism | Allergies | Amnesia | Anemia | Anxiety Disorder | Arthritis | Asthma | Cancer | Chicken Pox | Cold Sores | Colitis| Depression | Diabetes | Eating Disorders | Eczema | Emphysema | Epilepsy] Gall Stones | Goitre | Gonorrhea | Gout | Hay Fever | Heart Disease | Hepatitis | Herpes Gen. | Influenza | Kidney Disease | Leukemia | Malaria | Measles | Miscarriage | Mono | Mumps | Parasites |Pelvic Inflammatory Disease | Peritonitis | Pleurisy | Pneumonia | Post-partum depression |Prostatitis | Rheumatic Fever | Rubella |Scarlet Fever | Schizophrenia |Sexual Abuse | Skin Disease | Strep Throat | Sinusitis | Sunstroke | Stroke | Syphilis | Tonsillitis | Tuberculosis | Typhoid Fever | Venereal Warts | Warts | Whooping Cough | Worms | Yellow Fever

ANY OTHER MAJOR CONDITIONS?:_____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL SINCE OR WHICH WERE MORE SEVERE THAN USUAL? ◯***YES*** ◯***NO***

IF YES, WHICH ONES? _____

HAVE YOU LOST ANY WEIGHT LATELY? ◯***YES*** ◯***NO***

IF YES, HOW MANY POUNDS? _____

WHAT EXERCISE DO YOU DO AND HOW MUCH?_____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

- ☐ ***TOBACCO_____***
- ☐ ***ALCOHOL_____***
- ☐ ***COFFEE_____***
- ☐ ***"RECREATIONAL DRUGS"_____***

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

- ***HOMEOPATH NAME:_____***
- ***WHEN?_____***

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE (eg ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, etc)? ◯***YES*** ◯***NO***

IF YES, PLEASE SPECIFY:_____

ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, etc? ◯***YES*** ◯***NO***

IF YES, PLEASE SPECIFY:_____

HEALTH HISTORY OF RELATIVES

RELATIVE	AGE IF ALIVE	AGE AT & CAUSE OF DEATH IF DECEASED	AILMENTS
MOTHER			
FATHER			
BROTHERS			

RELATIVE	AGE IF ALIVE	AGE AT & CAUSE OF DEATH IF DECEASED	AILMENTS
SISTERS			
CHILDREN			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL AUNTS/UNCLES			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
PATERNAL AUNTS/UNCLES			

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CASE THAT YOU WOULD LIKE TO MENTION? ◯***YES*** ◯***NO***

IF YES, PLEASE EXPLAIN:_____

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.