This **ACUTE PATIENT** form is a confidential health assessment tool, which will assist us in treating you safely. Please take the time to answer the questions on this form as accurately as possible.

Contact Information:
ACUTE PATIENT Name: ______________________ **Date of visit:**__________ **Weight:** _______ **Height:** ________

Birthday: MM/DD/YYYY Age:____ Male / Female
Address Street Name:_______________ Apt/Suite _____ City: ________ Postal Code: ________
Home Tel : (___) ___ ___ Mobile: (___) ___ ___ Work Tel : (___) ___ _____
Email address: ______________@______________________

In Case Of Emergency?___________________________
Name: ____________ Relationship: ____________ Tel: (___) ___ ____
Family Physician Name: ______________ Phone Number: (___) ___ ____
Address Street Name:_______________ Apt/Suite # ____________
City:_______________ Postal Code: ____________
Have you been treated by a homoeopath before? Y N If yes, please list the name and contact information.
Name:__________ Contact:__________ Name:__________ Contact:__________
Name:__________ Contact:__________ Name:__________ Contact:__________
How Did You Hear About Our Homeopathic Clinic? Internet Newspaper Referred by:______________
Other? ______________________________________

Chief Concern

What is the nature of your acute condition? Since when?

____

What medications &/or supplements are you taking for this problem?

____

Are you receiving any other treatment for this problem? If so, what and by whom?

____

What do you feel was the cause of this problem?

____

Sensation/Feeling:

Describe how this acute condition feels? (For examples reverse): ______________________

____

Are there any other sensations that occur with your acute condition? (For examples see reverse):

____

What is the intensity of your condition? (Please circle)

Very Mild 0------1------2------3------4------5------6------7------8-----9-----10 Extremely intense
Moderate

TIME: ______________________________________
How frequently do you experience the effects of this problem? (Please circle one or more)
a) Constantly b)Hourly c) Daily d) Nightly
h) Other: ______________________________________

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MODALITIES:

Indicate with a **W** any of the following that make your condition **WORSE**

Indicate with a **B** any of the following that make your condition **BETTER**

TEMPERATURE		**ENVIRONMENT**		**MOTIONS**		**BODY FUNCTIONS**
Heat		Damp		Commencing motion		Eating
Heat in general		Humid		Continued motion		Drinking
Heat of the sun		Windy		Exertion		Urinating
Warmth of a bed		Weather Changes		Rising Up		Defecating
Warm rooms		Overcast/Stormy		Resting		Sleeping
Application of heat		At an altitude		Stretching		Coughing
Warm water		Indoors		Lifting		Yawning
Cold		Outdoors		**POSITION**		Sneezing
Cold in general		By the sea		Lying		Sexual Activity
Cold air/draft		Other		Standing		Other
Cold water		**SENSORY**		Sitting		**PHSYCOLOGICAL**
Cold application		Touch		Stooping		Excitement
		Pressure		Stretched out		Effects of Anger
		Noise		Doubled up		Fear or shock
		Music		Right side		Stress
		Light		Left side		Worry
		Darkness		Stiff		Thinking about it
		Odors		Limp		While busy

Associated Symptoms:

Do you experience any other symptoms at the same time as this pain? (ex. diarrhea, perspiration, nausea):

____

____

How do you feel mentally/emotionally with this problem? ______________________

____

____

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Patient Agreement Form – Homeopathy

I acknowledge that homeopathic treatment and conventional medical treatments are different but can complement each other. I confirm that there has been no suggestion made to me that I refrain from seeking or following conventional medical treatment. I confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.
All information disclosed is confidential except where disclosure is authorized or required by law.
I understand that there may be occasions when an aggravation of my current symptoms or a return of previous symptoms may occur as part of the healing process.

I authorize discussion of my case notes with other professional homeopaths if assistance in remedy selection and/or symptom analysis be required, or my best interest be served by such a consultation in the opinion of my homeopath. In doing so, my right to privacy will be protected by the changing or withholding of my name and all other identifying information.
I understand that a 24-hour notification is required if I cancel the appointment. I understand that there is a charge for appointments cancelled less than 24 hours in advance.
I understand the cost of treatment and agree to pay my account according to the guidelines of the clinic. I also understand that all fees are non-refundable.

Cost of Treatment*	**Adults**	**Children (Ages 0 – 18) and Seniors (Ages 65 +)**
Initial Constitutional Consultation (90- 120 Minutes)	$225.00	$165.00
Follow-Up Visit (30-45 Minutes)	$85.00	$65.00
Acute Consultation (30 Minutes)	$60.00	

Family Rate:

Second Child And All Other Children Under The Age Of 18	$145.00

I have read the above and agree to all terms:

Signature of patient: ______________________ (Parent/ Guardian if the patient is under the age of 18) ______________________

Date: ______________________

*Tax is not included in consultation fees.
*consultations are covered by most extended health insurance plans; please check your insurance plan in advance.

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