This intake 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: **Date of visit:** _____ **Weight:** _____ **Height:** _____

Child name: _____

Birthday: MM/DD/YYYY Age:____ Male / Female

Parent Contacts Street Name: _____ Apt/Suite _____ City: _____ Postal Code: _____

Mother Home Tel : (___) ___ ___ Mobile: (___) ___ ___ Work Tel : (___) ___ _____

Email address: _____@_____

Father 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? _____

Current Health Concerns please list in order of importance to you:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Can you trace the origin of the present illness to any particular? _____

Circumstance, Accident, Illness, Incident Or Mental Upset. (E.g. Shock, Trauma, Worry, Errors In Diet) _____

Overexertion, Overexposure To Cold, Heat Etc)? _____

Medical History:

Please list any major surgeries your child has had in the past.

_____

Has your child any injuries?

_____

Has your child been vaccinated? Y ¨ N ¨ If yes, did he/she have any adverse reaction? _____

□ Measles □ Mumps □ Rubella □ Pertussis □ Chicken Pox □ Flu □ Other

Has your child lost any weight recently? Y ¨ N ¨ If yes, How Much? _____

Date of last annual physical exam /blood test: _____

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Medical History (continued):

Allergies/sensitivities (foods, drugs, pets, seasonal, etc.): _____

_____

_____

List of medications & nutritional supplements:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Has your child ever been diagnosed with any of the following conditions?

Alcoholism ¨	Diabetes ¨	Hypertension ¨	Measles ¨	Rheumatic Fever ¨
Venereal Warts ¨	Eczema ¨	Hepatitis ¨	Mental Problems ¨	Sexual Abuse ¨
Warts ¨	Allergies ¨	Epilepsy ¨	Herpes ¨	Miscarriage ¨
Skin Disease ¨	Cough ¨	Anaemia ¨	Emphysema ¨	Influenza ¨
Mononucleosis ¨	Strep Throat ¨	Worms ¨	Appendicitis ¨	Gall Stones ¨
Jaundice ¨	Mumps ¨	Sinusitis ¨	Yellow Fever ¨	Asthma ¨
Goitre ¨	Kidney Disease ¨	Nosebleeds ¨	Stroke ¨	Bronchitis ¨
Gonorrhoea ¨	Pneumonia ¨	Parasites ¨	Syphilis ¨	Chicken Pox ¨
Gout ¨	Leukaemia ¨	Tonsillitis ¨	Thyroid Conditions ¨	Cold Sores ¨
Hay Fever ¨	Liver Disease ¨	Prostatitis ¨	Tuberculosis ¨	Depression ¨
Heart Disease ¨	Malaria ¨	Psoriasis ¨	Head Injuries ¨	Crohn's Disease ¨
Gastric Ulcer ¨	Glaucoma ¨	Skin Conditions? Please explain: _____		

Cancer? Y ¨ N ¨ Please explain: _____

Other? Please explain: _____

Female Reproductive System

Circle what describes your child periods the best: Regular / Irregular / No Periods / Peri-Menopausal / Menopausal

Date of last normal period: _____

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medication, or supplements with you.

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Child's Birth History

Birth Weight:_____ Rh Blood Problems?_____

Any complications during and/or after delivery? _____

Number of hours in labour: _____

Was the delivery:

□ Normal □ Premature □ Caesarean □ Forceps aided

□ At home □ In hospital □ Drug aided □ Difficult

Was the child breastfed? _____ If yes, for how long?_____

If NO, Type of formula used? _____

At what age was: milk introduced?_____ Solid foods?_____

What foods were first introduced? _____

Mother's Pregnancy History

Did you have any problems conceiving?_____

Did you have a stressful pregnancy?_____

Did you experience any of the following?

□ Anaemia □ Fatigue □ Nausea □ Vomiting

Did you use any of the following during pregnancy?

□ Alcohol □ Antibiotics □ Cigarettes

□ Iron supplements drugs □ Recreational □ Sedatives

□ Sleeping pills □ Other _____

Did you undergo x-rays? _____ Ultrasound? _____

How much weight did you gain during pregnancy? _____

Did you have any food cravings or aversions during pregnancy? If yes, what were they? _____

_____

During the pregnancy, did you suffer any shocks, traumas, or losses? If yes, explain_____

_____

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Child information:

Has your child experienced any Stress, Trauma, Loss or Life Changing Trauma in your life? _____

_____

Please check which of the following substances your child are currently using.

¨Alcohol how much?_____ ¨Pain killers how much? _____

¨Recreational drugs how much? _____ ¨Cigarettes how much? _____

¨Sleeping pills how much? _____ ¨Coffee? How much? _____

¨Laxatives/Purgatives how much?_____ ¨Tea? How much? _____

How many hours of sleep does your child get each night? _____

Does he/she wake in the night? Y ¨ N ¨ For any particular reason? _____

At any particular time?_____ How long does it take to fall back asleep?_____

General energy level out of 10 (1=lowest, 10=highest): 1¨ 2¨ 3¨ 4¨ 5¨ 6¨ 7¨ 8¨ 9¨ 10¨

What time of day is it highest? _____ Lowest? _____

Special diet? Y ¨ N ¨ Explain: _____

Details about your Child's symptoms:

What triggers the symptoms (mental, emotional and physical symptoms)?

_____

Does anything make the symptoms unique?

_____

What makes the symptoms better (i.e. hot/cold, eating, sleep, time of day)?

_____

What makes the symptoms worse?

_____

Is the child affected by the weather? How?

_____

Perspiration (odour, night sweats, profuse)?

_____

Body temperature: _____

Is there anything else regarding the child's overall condition that we should know?

_____

_____

_____

_____

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medication, or supplements with you.

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Family History:

Please check any of the following ailments which may be present in your family history:

Alcoholism	Diabetes	Heart Disease	Multiple Sclerosis
Alzheimer's Disease	Drug Abuse	High Blood Cholesterol	Osteoporosis
Asthma	Eczema	High Blood Pressure	Osteoarthritis
Cancer	Epilepsy	Kidney Disease	Psoriasis
Depression	Fibromyalgia	Mental Illness	Thyroid Disorder

Relationship	Age	If deceased, age at death	Cause of Death	Diseases
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Grandfather				
Aunts				
Uncles				
Paternal Grandmother				
Grandfather				
Aunts				
Uncles				

Is there anything else that you feel that hasn't been addressed on this form?_____

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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)	$250.00	$185.00
Follow-Up Visit (30-45 Minutes)	$85.00	$75.00
Acute Consultation (30 Minutes)	$75.00	

Family Rate:

Second Child And All Other Children Under The Age Of 18	$165.00

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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