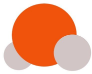

Adult History and Information

This intake form is a confidential health assessment tool, which will assist us with your treatment. Please take the time to answer the questions on this form as accurately as possible.

Contact Information:

Patient name: Date of visit:

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

Address Street Name:___________________________ Apt/Suite # ______________

City: _______________________________ Postal Code: ______________

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

Email address: _______________________@________________

Status: Single / Married/ Partnered # Of Children: ___ Occupation:

In Case Of emergency who would like us to contact?

Name: _________________ Relationship: ________________ Tel: (___) ___ ____

Family Physician Name: ____________________ Phone number: (___) ___ ____

Have you been treated by a homoeopath before? Y ¨ N

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 you have had in the past.

Have you had any injuries?

Have you been vaccinated? Y ¨ N ¨ If yes, did you have any adverse reaction?

Have you lost any weight recently? Y ¨ N ¨ If yes, How Much?

Date of last annual physical exam /blood test:

Do you have any Internal Pins/Wires, Artificial Limbs, Special Equipment? Y ¨ N ¨
Please explain:

Do you have any allergies/sensitivities (foods, drugs, pets, seasonal, etc.):

List of medications & nutritional supplements:
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Female Reproductive System

Circle what describes you periods the best:
Regular / Irregular / No Periods / Premenopausal / Menopausal

Date of last normal period: ________________ PMS symptoms:

Are you currently pregnant: Y ¨ N ¨ Due Date:_____________

Personal information:

Occupation: Is your occupation associated with any potential life/ health threatening condition? Please specify

Have you experienced any Stress, Trauma, Loss or Life Changing Trauma in your life?

Please check which of the following substances you 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 do you get each night?
Do you wake feeling Rested? Y ¨ N ¨

Do you 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¨

Childhood History:

Were you Breastfed? Y ¨ N ¨ If yes, for how long?

Were you Immunized? Y ¨ N ¨ If yes, any reactions?

Family History:

Please mention any specific ailments which may be present in your family history:

Relationship	Age	Disease	age at death, if deceased	Cause of Death
Mother				
Maternal grandmother				
Maternal Grandfather				
Father				
Paternal grandmother				
Paternal grandfather				
Sister(s)				
Brother(s)				

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