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?

____

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.

Mahsa Asasi, Pharm D., DIHom, DHMHS
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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?

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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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	$195.00
Follow-Up Visit (30-45 Minutes)	$85.00	$75.00
Acute Consultation (30 Minutes)	$75.00	

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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