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: _____

Patient name: _____

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

Address Street Name: _____ Apt/Suite # _____

City: _____ Postal Code: _____

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

Email address: _____@_____

Best Way To Reach You? _____

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

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 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: _____

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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. _____

Have you 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 you periods the best: Regular / Irregular / No Periods / Peri-Menopausal / Menopausal

Date of last normal period: _____ **PMS symptoms:** _____

_____

_____

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

Delivering Hospital/Midwife: _____

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Personal information:

Occupation,

Is your occupation is 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¨

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

Are you on a special diet? Y ¨ N ¨ Explain: _____

Childhood History:

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

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

Which "Childhood" illnesses did you have?

Eczema¨	German Measles¨	Mumps¨	Polio¨
Frequent Ear Infections¨	Meningitis¨	Measles¨	Rheumatic Fever¨
Chicken Pox¨	Whooping Cough¨	Thrush/Candida¨	Autism¨
ADD/ADHD ¨			

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¨

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Family History (continued):

Relationship	Age	If deceased, age at death	Cause of Death	Diseases
Father				
Paternal Grand Father				
Paternal Grand Mother				
Mother				
Maternal Grand Mother				
Maternal Grandfather				

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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