

Homeopathic Patient Intake Form - Acute Consultation

Date: _____

Name:		
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Email:
Weight:	Height:	
Emergency Contact Name:		Phone:
Date of Birth:	Age:	Sex:

Chief Concern:

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

What medications and/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: _____

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

