Adult Homeopathic Intake Form

The information contained herein is strictly confidential.
Please fill out all appropriate pages completely and to the best of your knowledge.

(Please Print)			
Today's Date:			
PATIENT INFORMATION			
Last Name:	○ Mr. ○ Mrs.	○ Miss. ○ Ms.	Marital Status:
First Name:	Date of Birth:	Age:	Email Address:

Street Address:	Contact Number: (H) (C)	Number of Children:
City:	Province:	Postal Code:
Occupation:	Employer:	Work Place Phone Number:

Referred by (check one):	
○ Clinic Staff	○ Hospital
○ Family Member	○ Friend
○ Insurance Plan	○ Website
○ Doctor	○ Other (please specify): _____

Name and phone number of Family Physician:
Name and phone number of previous Homeopath:

IN CASE OF EMERGENCY		
Emergency Contact Name:	Phone Number:	Work Phone Number:

VITAL STATISTICS			
HEIGHT:	WEIGHT:	B.P.:	PULSE:

What is your main health concern, and when did it start?

_____

Was it preceded by an event, accident, or mental upset? (i.e. shock, worry, dietary, overexertion, weather?)

_____

Does anything make it better, or worse?

_____

Do you have any additional health concerns? Please list in order of importance to you and provide date of onset:

_____

_____

_____

Please check if you have ever had any of these conditions:

O Abscesses
O Alcoholism
O Anaemia
O Appendicitis
O Arthritis
O Asthma
O Cancer
O Chicken Pox
O Cold Sores
O Depression
O Diabetes
O Eczema
O Epilepsy
O Emphysema
O Gall Stones
O Goitre
O Gonorrhoea
O Headaches
O Heart Trouble
O Hypertension
O Hepatitis
O Herpes
O Influenza
O Jaundice
O Kidney Disease
O Leukemia
O Liver Disease
O Malaria
O Measles
O Mental Illness
O Mononucleosis
O Mumps
O Nosebleeds
O Parasites
O Pelvic Inflammatory Disease
O Pneumonia
O Prostate Disease
O Rheumatic Fever
O Skin Disease
O Strep Throat
O Sinusitis
O Stroke
O Gout
O Syphilis
O Tonsillitis
O Tuberculosis
O Venereal Warts
O Warts
O Whooping Cough
O Worms

O Others?: _____

Indicate your use of the following:

	Per Day	Per Week	Per Month
Tobacco			
Alcohol			
Coffee			
Recreational Drugs			

What vaccinations have you had? List any reactions:

_____

_____

_____

What exercises do you do, and how often?

_____

_____

_____

List any treatments, medicines, supplements, homeopathic remedies, etc. that you are taking:

Treatment or Medicine:	When and for How Long?	Effect on You:
Any Major Surgeries?	When?	Complications?
Major Injuries?	When?	Complications or Long-Term Effects?

Family History: Please indicate which ailments affect(ed) your family. These can include:

O Alzheimer's
O Alcoholism
O Asthma
O Arthritis
O Cancer
O Diabetes
O Epilepsy
O Gonorrhoea
O Hypertension
O Heart Disease
O Hepatitis
O Depression
O Skin Disease
O Syphilis
O Tuberculosis
O Ulcers
O Mental Illness
O Pneumonia

O Others (please specify): _____

Relationship	Current Age	Age at Death	Cause of Death	Disease(s)
Mother				
Maternal Grandfather				
Maternal Grandmother				
Father				
Paternal Grandfather				
Paternal Grandmother				
Sister(s)				
Brother(s)				

Systems Review: Please check with a checkmark if you are currently suffering from, and with an "X" if you have suffered in the past, any of the following disorders:

Skin:

____ Rashes ____ Eczema ____ Hives ____ Acne
____ Boils ____ Itching ____ Lumps ____ Dry Hair
____ Dryness ____ Scaling ____ Moles ____ Warts
____ Falling/Thinning Hair ____ Colour Changes ____ Nail Changes

Head:

____ Headache ____ Dizziness ____ Vertigo ____ Migraines
____ Head Injuries

Eyes:

____ Eye Pain ____ Tearing ____ Dryness ____ Glaucoma
____ Double Vision ____ Cataracts ____ Blurring ____ Itching
____ Redness ____ Discharge ____ Impaired Vision

Ears:

____ Ringing ____ Buzzing ____ Earache ____ Redness
____ Discharge ____ Infections ____ Impaired Hearing

Nose/Sinuses:

____ Frequent Colds ____ Stuffiness ____ Hay Fever ____ Nose Bleeds
____ Obstruction ____ Loss of Smell ____ Nasal Discharge ____ Sinus Problems

Mouth and Throat:

____ Sore Throats ____ Cankers ____ Dry Lips ____ Bleeding Gums
____ Receding Gums ____ Loss of Taste ____ Dental Cavities

Neck:

____ Lumps ____ Goitre ____ Swollen Glands ____ Pain or Stiffness
____ Difficulty Swallowing

Respiratory:

____ Cough ____ Sputum ____ Spitting Blood ____ Wheezing
____ Asthma ____ Bronchitis ____ Pneumonia ____ Emphysema
____ Difficulty Breathing ____ Shortness of Breath ____ Allergies

Cardiovascular:

____ Palpitations ____ Chest Pain on Exertion _____ Blueness of Lips ____ Swelling of Ankles
____ High Blood Pressure ____ Low Blood Pressure

Gastrointestinal:

____ Heartburn ____ Nausea ____ Vomiting ____ Constipation
____ Diarrhea ____ Gas ____ Belching ____ Bloating
____ Abdominal Pain ____ Lack of Appetite ____ Ineffectual Urging ____ Haemorrhoids
____ Indigestion ____ Food Allergies

Musculoskeletal:

____ Pain in Joints ____ Swollen Joints ____ Stiffness in Joints ____ Broken Bones
____ Muscle Spasms ____ Cramps ____ Muscle Twitching

Peripheral Vascular:

____ Deep Leg Pain ____ Cold Hands ____ Cold Feet ____ Varicose Veins
____ Ulcers ____ Extremity Numbness ____ Extremity Coldness ____ Extremity Swelling

Endocrine:

____ Cold Intolerance ____ Excess Thirst ____ Excess Hunger ____ Sudden Weight Gain
____ Sudden Weight Loss ____ Heat Intolerance ____ Excess Sweating

Neurological:

____ Fainting ____ Convulsions ____ Paralysis ____ Tremors
____ Numbness ____ Tingling ____ Weakness ____ Loss of Memory
____ Involuntary Movements ____ Difficulty Concentrating _____ Speech Problems
____ Difficulty Initiating Movements

Reproductive System - Females:

____ Menstrual Problems ____ Sexual Difficulties ____ Pain/Dryness During Intercourse
____ Problems Achieving Orgasm ____ Difficulties Conceiving or Carrying a Pregnancy
____ Venereal Disease
Age of First Menses_____

Date of Last Menses _____

Reproductive System - Males:

____ Testicular Pain ____ Testicular Masses ____ Abnormal Penile Discharges
____ Sexual Difficulties ____ Erectile Difficulties ____ Fertility Difficulties
____ Enlarged Prostate ____ Venereal Disease