HOMEOPATHIC CONSULTATION

ADULT Intake Form #1

Patient CONTACT INFORMATION

PATIENT'S NAME						
Address:	Street/#		City		Postal code	
Contact tel. # HOME:						
Contact tel. # OTHER:						
E-Mail:						
Date of Birth:						
Referred by:						
How did you learn about our clinic?						
Family M.D.:	Name		Tel #			

Patient INTAKE FORM

PERSONAL ATTRIBUTES	DETAILS					
Date of Birth:						
Gender:						
Hair Color:						
Eye Color:						
Weight Recent History:	Current		Highest Recent		Lowest Recent	
Current marital status:						
Occupation:						

MEDICAL HISTORY	DETAILS		
	Concern	Since	Causes
CURRENT MAJOR HEALTH CONCERNS in ORDER OF IMPORTANCE (Highest FIRST)			

MEDICAL HISTORY Continued	DETAILS		
MEDICATIONS you have taken in THE LAST YEAR:	**MEDICATION**	**Since**	**Adverse effects**
Major Non-Surgical TREATMENTS received in the past and currently:	**TREATMENT**	**When**	**Complications**
Major OPERATIONS/ INJURIES	**OPERATION/INJURY**	**When**	**Complications**

MEDICAL HISTORY Continued	DETAILS					
VACCINATION History	Measles	☐	Mumps	☐	Rubella/German Measles	☐
	Chicken Pox	☐	Whooping Cough	☐	Meningitis	☐
	Hep B	☐		☐		☐
	ANY ADVERSE REACTIONS TO THESE VACCINATIONS?					
ALLERGY History Please Describe allergies you have experienced?						
CONDITIONS Tick the box if you have experienced any of the conditions listed opposite:	Abscesses	☐	Gallstones	☐	Mononucleosis	☐
	Anemia	☐	Gout	☐	Multiple Sclerosis	☐
	Arthritis	☐	Heart Disease	☐	Mumps	☐
	Cancer	☐	Hepatitis	☐	Parasites	☐
	Chicken Pox	☐	HIV	☐	Pelvic Inflamm. Dz.	☐
	Cold Sores	☐	Influenza	☐	Peritonitis	☐
	Diabetes	☐	Kidney Disease	☐	Psoriasis	☐
	Eczema	☐	Leukemia	☐	Rheumatic Fever	☐
	Emphysema	☐	Lyme Disease	☐	Rubella	☐
	Epilepsy	☐	Malaria	☐	Scarlett Fever	☐
	Frequent Colds	☐	Measles	☐	Sexually Tx. Dz.	☐
	Skin Diseases	☐	Sunstroke	☐	Venereal Warts	☐
	Sinusitis	☐	Tonsillitis	☐	Warts	☐
	Strep Throat	☐	Tuberculosis	☐	Whooping Cough	☐
	Stroke	☐	Typhoid Fever	☐	Worms	☐
	Yellow Fever	☐		☐		☐
	OTHER					

MEDICAL HISTORY Continued	DETAILS							
SUBSTANCE USE **Tick any of the items listed opposite which you USE?**	Alcohol	☐	Antacids	☐	Carbonated beverages	☐		
	Coffee	☐	Distilled water	☐	Fast foods	☐		
	Fried foods	☐	Laxatives	☐	Margarine	☐		
	Non-sugar sweetener	☐	Salt (without tasting)	☐	Sweets	☐		
	Tea	☐	Tobacco	☐	Other			
NUTRITIONAL SUPPLEMENTS **List any NUTRITIONAL SUPPLEMENTS you use:**								
SUFFERED FROM **Tick any of the items listed opposite & which you SUFFER FROM, past or present?**	Abortion	☐	Alcoholism	☐	Depression	☐		
	Drug Abuse	☐	High/Low Blood pressure	☐	Miscarriage	☐		
	PMS	☐	Sexual Abuse	☐	Other			
	OTHER (Specify)							
SYMPTOMS **Tick any of the SYMPTOMS you have experienced, past or present:**	**SYMPTOM GROUP**				**SYMPTOM GROUP**			
	Mouth/Throat				**Emotions**			
	Chronic Coughing	☐			Mood Swings	☐		
	Gagging, frequent need to clear throat	☐			Anxiety, fear of nervousness	☐		
	Sore throat, hoarseness, loss of voice	☐			Anger, irritability, aggressiveness	☐		
	Swollen or discolored tongue, gums, lips	☐			Depression	☐		
	Canker sores	☐				☐		

MEDICAL HISTORY Continued	DETAILS			
SYMPTOMS **Tick any of the SYMPTOMS you have experienced, past or present:**	**Mind**		**Energy / Activity**	
	Poor memory	☐	Fatigue, sluggishness	☐
	Confusion, poor comprehension	☐	Apathy, lethargy	☐
	Poor concentration	☐	Hyperactivity	☐
	Poor physical co-ordination	☐	Restlessness	☐
	Difficulty in making decisions	☐	Insomnia	☐
	Stuttering or stammering	☐	Trouble getting out of bed	☐
	Slurring speech	☐	Nightmares	☐
	Learning disabilities	☐		☐
	Lungs		**Heart**	
	Chest congestion	☐	Irregular or skipped heartbeat	☐
	Asthma, bronchitis	☐	Rapid or pounding heartbeat	☐
	Shortness of breath	☐	Chest Pain	☐
	Difficulty breathing	☐		
	Head		**Digestive Tract**	
	Headaches/Migraines	☐	Nausea, vomiting	☐
	Faintness	☐	Bloated feeling	☐
	Dizziness	☐	Belching	☐
	Insomnia	☐	Heartburn	☐

MEDICAL HISTORY Continued	DETAILS			
SYMPTOMS **Tick any of the SYMPTOMS you have experienced, past or present:**	**Eyes**		**Elimination**	
	Watery or itchy eyes	☐	Diarrhea/constipation (circle one)	☐
	Swollen, reddened or sticky eye lids	☐	Intestinal cramps	☐
	Bags or dark circles under eyes	☐	Passing gas	☐
	Blurred or tunnel vision	☐	Frequent urination	☐
		☐	Painful urination	☐
		☐	Blood in waste products	☐
		☐	Mucous in waste products	☐
	Ears		**Joint / Muscles**	
	Itchy ears	☐	Pain or aches in joint	☐
	Earaches or ear infections	☐	Arthritis	☐
	Drainage from ear	☐	Stiffness or limitation of movement	☐
	Ringing in ears, hearing loss	☐	Pain or aches in muscles	☐
			Feeling of weakness or tiredness	☐
	Nose		**Skin**	
	Stuffy nose/Sinus problems	☐	Acne	☐
	Hay fever/Allergies	☐	Hives, rashes or dry skin	☐
	Sneezing attacks	☐	Hair loss	☐
	Excessive mucous formation	☐	Flushing or hot flashes	☐
		☐	Excessive sweating	☐
	Weight			
	Binge or compulsive eating/drinking	☐	Under weight	☐
	Craving certain foods	☐		
	Excessive weight	☐		
	Water retention	☐		

MEDICAL HISTORY Continued	DETAILS	
PHYSICIAN CARE	**PHYSICIAN'S NAME**	
	YOUR CONDITIONS AND TREATMENT	
PREVIOUS HOMEOPATHIC TREATMENTS **Please describe any previous Homeopathic treatment you have experienced:**		
ADDITIONAL INFORMATION **which you care to add & which is not covered anywhere else in this document:**		

FAMILY MEDICAL HISTORY	DETAILS			
	Relative	**AGE If Alive**	**Age At Death**	**Ailments**
History Of Relatives	Mother			
	Father			
	Brothers			
	Sisters			
	Maternal Grandmother			
	Maternal Grandfather			
	Maternal Uncles/Aunts			
	Paternal Grandmother			
	Paternal Grandfather			
	Paternal Uncles/Aunts			

Date Form Prepared:		**Prepared by:**	