

Adult Homeopathic Intake Form

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

(Please Print)			
Today's date:			
PATIENT INFORMATION			
Last name:	q Mr. q Mrs.	q Miss q Ms.	Marital status :
First name:	Date of birth:	Age:	Email address:
Street address:	Contact Numbers: (h) (c)		Number of children
City:	Province:		Postal Code:
Occupation:	Employer:		Work phone no.:
Referred by: (check one)	q Centre staff q Family qHospital qClose to home or work q Insurance plan q Dr. qFriend qWebsite		
Name and phone no. of Family Physician:			
Name and phone no. of previous Homeopath:			
IN CASE OF EMERGENCY			
Emergency contact person:	Home phone no.:		Work phone no.:
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? (ie. shock, worry, dietary, overexertion, weather?)

Does anything make it better?

Worse?

Do you have any other health concerns? Please list in order of importance for you, and the date of onset.

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

- | | | |
|---------------------------------------|---|--|
| ☐ Abscesses | ☐ Headaches | ☐ Pelvic inflammatory disease |
| ☐ Alcoholism | ☐ Heart trouble | ☐ Pneumonia |
| ☐ Anaemia | ☐ Hypertension | ☐ Prostate disease |
| ☐ Appendicitis | ☐ Hepatitis | ☐ Rheumatic fever |
| ☐ Arthritis | ☐ Herpes | ☐ Skin disease |
| ☐ Asthma | ☐ Influenza | ☐ Strep throat |
| ☐ Cancer | ☐ Jaundice | ☐ Sinusitis |
| ☐ Chicken pox | ☐ Kidney disease | ☐ Stroke |
| ☐ Cold sores | ☐ Leukemia | ☐ Gout |
| ☐ Depression | ☐ Liver disease | ☐ Syphilis |
| ☐ Diabetes | ☐ Malaria | ☐ Tonsillitis |
| ☐ Eczema | ☐ Measles | ☐ Tuberculosis |
| ☐ Epilepsy | ☐ Mental illness | ☐ Venereal warts |
| ☐ Emphysema | ☐ Mononucleosis | ☐ Warts |
| ☐ Gall stones | ☐ Mumps | ☐ Whooping cough |
| ☐ Goitre | ☐ Nosebleeds | ☐ Worms |
| ☐ Gonorrhoea | ☐ Parasites | |

☐ 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 exercise do you do and how much?

List any treatments, medicines, supplements, homeopathic remedies 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 what ailments affect(ed) your family. These can include:

☐ Alzheimer's
☐ Alcoholism
☐ Asthma
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Depression

☐ Epilepsy
☐ Gonorrhoea
☐ Hypertension
☐ Heart disease
☐ Hepatitis
☐ Mental illness
☐ Pneumonia

☐ Skin diseases
☐ Syphilis
☐ Tuberculosis
☐ Ulcers
☐ Others* Specify below

* _____

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 ✓ if you are currently suffering from, or with a P if you have suffered from any of the following disorders in the past:

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

Neurological:

___ fainting ___ convulsions ___ paralysis ___ tremors
 ___ numbness ___ tingling ___ weakness ___ involuntary movements
 ___ loss of memory ___ difficulty concentrating ___ loss of balance
 ___ difficulty initiating movements ___ speech problems

Endocrine:

___ cold intolerance ___ excess thirst ___ excess hunger ___ sudden weight gain
 ___ sudden weight loss ___ heat intolerance ___ excess sweating

Reproductive system – FEMALES:

___ menstrual problems ___ sexual difficulties ___ pain/dryness during intercourse
 ___ problems achieving orgasm ___ difficulties conceiving or carrying a pregnancy to term
 ___ 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