HOMEOPATHIC CONSULTATION – INTAKE FORM

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Patient Information

Last Name:	First Name:	
Address:	City:	Postal Code
Home phone:	Work:	Cell:
Email	Date of birth:	
Referred by:		
Present MD and phone #:		

Health Information

Major complaints in order of importance to you	Since	Causes

What medications and vitamins are you currently taking?	Since	Any adverse effects?

What treatments or therapies are you currently following?	Since	Results

Please indicate which of the following conditions you have had:

Abscesses		Colitis		Gout		Mono		Sexual abuse		Typhoid fever	
AIDS/HIV		Constipation		Hay fever		Mumps		Skin disease		Venereal warts	
Alcoholism		Depression		Heart disease		Parasites		STD		Warts	
Allergies		Diabetes		Hepatitis		Peritonitis		Strep throat		Whooping cough	
Anaemia		Diarrhoea		Herpes		PID		Sinusitis		Worms	
Arthritis		Eczema		Influenza		Pleurisy		Stroke		Yellow fever	
Asthma		Epilepsy		Kidney disease		Pneumonia		Sunstroke			
Bronchitis		Emphysema		Leukemia		Prostatitis		Syphilis			
Cancer		Gallstones		Malaria		Rheumatic fever		Thyroid issues			
Chicken pox		Goitre		Measles		Rubella		Tonsillitis			
Cold sores		Gonorrhoea		Miscarriage		Scarlet fever		Tuberculosis			

Do you have any other major conditions?

Are there any of the preceding conditions after which you have never been totally well again? If so, which one(s)?

General Health & Lifestyle

Have you gained or lost any weight lately? Yes ☐ No ☐	How many pounds?	
What exercise do you do and how much?		
How much of the following substances are you using?		
Tobacco:	Alcohol:	
Tea/Coffee:	Recreational drugs:	
Are you currently under the care of any other physician(s)?		
Who?	For what conditions?	Treatment

Have you ever been treated by homeopathy before?		
Homeopath	When?	For what condition(s)?

Can you trace the origin of any present condition to any particular circumstance (i.e. accident, illness, incident, mental upset, etc.)?

Do you have any history of serious shock, grief, disappointment, fright, depression, etc.?

Women Only	
Age of first period:	Number of pregnancies:
Number of miscarriages:	Any abortions?
Complications from any of the above:	

Vaccination / Illness & Injury History

What vaccinations have you had?

Have you ever had an adverse effect from a vaccination? If so, please describe:

Injuries / Surgery	
Type:	Since:
Type:	Since:

Health History of Relatives

Please indicate which of the following conditions your relatives have had

Alcoholism		Asthma		Diabetes		Gout		Mental Health issues		Skin disease	
Allergies		Cancer		Epilepsy		Hay fever		Paralysis		Syphilis	
Arthritis		Depression		Gonorrhoea		Heart disease		Pneumonia		Tuberculosis	

Have they had any other major ailments?

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other: _____			

Additional Information

Is there anything else that you feel is important to your case that you would like to mention?

Thank you for taking the time to complete this form.
All information contained herein will remain strictly confidential.