Homeopathic Medicine
& WELLNESS

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Patient Intake Form - Adult

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:	EMAIL :		
First name:	Date of birth:	Age:	Marital status :
Street address:	Contact Numbers: (h) (c)		Number of children
City:	Province:	Postal Code:	
Occupation:	Employer:	Work phone no.:	
How did you find me?	Family Dr.	Hospital Friend	Close to home or work Website
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 or 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
- ❑Alcoholism
- ❑Anaemia
- ❑Appendicitis
- ❑Arthritis
- ❑Asthma
- ❑Cancer
- ❑Chicken pox
- ❑Cold sores
- ❑Depression
- ❑Diabetes
- ❑Eczema
- ❑Epilepsy
- ❑Emphysema
- ❑Gall stones
- ❑Goitre
- ❑Gonorrhoea
- ❑Headaches
- ❑Heart trouble
- ❑Hypertension
- ❑Hepatitis
- ❑Herpes
- ❑Influenza
- ❑Jaundice
- ❑Kidney disease
- ❑Leukemia
- ❑Liver disease
- ❑Malaria
- ❑Measles
- ❑Mental illness
- ❑Mononucleosis
- ❑Mumps
- ❑Nosebleeds
- ❑Parasites
- ❑Pelvic inflammatory disease
- ❑Pneumonia
- ❑Prostate disease
- ❑Rheumatic fever
- ❑Skin disease
- ❑Strep throat
- ❑Sinusitis
- ❑Stroke
- ❑Gout
- ❑Syphilis
- ❑Tonsillitis
- ❑Tuberculosis
- ❑Venereal warts
- ❑Warts
- ❑Whooping cough
- ❑Worms

❑Others?____

Indicate your experience of the following:

	Per day	Per week	Per month
Tobacco			
Alcohol			
Coffee/Caffeine/Tea			
Recreational Drugs			
Water - # 8 oz glasses			
Bowel Movements			

What vaccinations have you had? List any reactions.

What exercise do you do and how often?

List any treatments, medicines, supplements, or homeopathic remedies you are taking:

Treatment/ Medicine/Supplements	Since 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 at any time now or in the past. 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:

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 ___ hemorrhoids
___ 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

Is there anything else I need to know in order to help you?