

GETTING OVER IT *Naturally*

Initial Consultation Form

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Homeopathy is an individualized process of prescribing a remedy. The remedy prescribed is suited to you and only you. In order to help find the best suited remedy I need you to complete this form. Please fill it out as accurately and in depth as you can. This will help me in completing an accurate picture and thus make our time together effective. Once completed, please bring this form with you to our first consultation.

If there are any questions or concerns please feel free to contact me. Please also be aware that all information discussed is kept in strictest of confidence according to the laws of the Homeopath – patient confidentiality. Although there is a strict code of confidentiality, I am obligated by law to report any suspicion of child abuse.

Thank you for your time and I look forward to meeting you.

Name _____

Address _____

Postal Code _____ Email _____

Home phone _____ Business phone _____

Date of birth _____ Height _____ Weight _____

Family Doctor's name and phone number _____

Referred by _____

Medical complaints: please list your major complaints in order of importance to you, how long have you had these complaints, and list the cause of the complaint if you know it.

Currently what medications are you on?

What complementary (massage therapy, nutritionist, etc.) treatments are you currently following?

Medical Conditions: *please circle all conditions that you have had in the past or that you currently have:*

Abscesses	Acne	Anaemia	Allergies	Anxiety	Arthritis
Asthma	Alcoholism	Cancer	Chicken Pox	Chronic Fatigue Syndrome	
Cirrhosis	Cold Sores	Colitis	Crohn's Disease	Chlamydia	Depression
Drug Abuse	Diabetes	Eczema	Elevated Cholesterol		Emphysema
Endometriosis	Epilepsy	Fibromyalgia	Frequent Colds	Gallstones	Goitre
Gonorrhoea	Gout	Heart Disease	Herpes (genitalia)	Hepatitis	HIV/AIDS
Hyperthyroidism	Hypothyroidism	Influenza	Intestinal Worms	Kidney Disease	Leukemia
Lyme Disease	Malaria	Measles	Migraines	Mononucleosis	Miscarriage
Multiple Sclerosis	Mumps	Parasites	Pelvic Inflammatory Disease		Pleurisy
PMS	Postmenopausal Symptoms		Polycystic Ovary Syndrome		Infertility
Peritonitis	Pneumonia	Prostatitis	Psoriasis	Polyps	Rheumatic Fever
Rubella	Scarlet Fever	Sinusitis	Skin Diseases	Syphilis	Strep Throat
Stroke	Sunstroke	Urinary Tract Infection		Tonsillitis	Tuberculosis
Typhoid Fever	Whooping Cough	Yellow Fever	High Blood Pressure		Low Blood Pressure

Other:

Surgeries and Major Injuries: *please list any surgeries you have undergone or any major injuries you have suffered*

Family History: *please circle all that apply*

- | | | | | | |
|------------|---------------|--------------------------|---------------------|-----------|-----------|
| Alcoholism | Allergies | Asthma | Alzheimer's Disease | Anxiety | Cancer |
| Depression | Dementia | Diabetes | Epilepsy | Gonorrhea | Gout |
| Hay Fever | Heart Disease | Mental Illness (specify) | | Migraines | Paralysis |
| Pneumonia | Skin Disease | Syphilis | Tuberculosis | | |

Other: _____

Vaccination History: *please list any adverse effects from any vaccinations that you have had*

Are there any preceding conditions from which you have never been well since?

List what you like to do (exercise, read, etc.):

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

Patient's Signature: _____ **Date:** _____

(If under 18 years of age, a parent or guardian must sign on your behalf)