

INTAKE FORM

Name : _____ Date : _____
Address : _____
City : _____ Postal Code : _____
Telephone Number : (Home) _____ Work : _____
Age : _____ Date of Birth : _____ Sex : F M
Marital Status : _____
Weight : _____ Height : _____
Number of children : _____ Number of Pregnancies : _____ Age at first menses (period) : _____
Occupation : _____ Employer : _____
Emergency Contact : _____ and Number : _____
How did you hear about our clinic? _____

Main Health Concerns in order of priority :

1. _____ Date started : _____
2. _____ Date started : _____
3. _____ Date started : _____
4. _____ Date started : _____

Any other health concerns? _____

Are you currently taking any medications or supplements?

Such as ... (and for how long?)

- | | |
|---|--|
| <input type="checkbox"/> Digestive enzymes | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Thyroid medicine |
| <input type="checkbox"/> Painkillers | <input type="checkbox"/> Megavitamins |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Hormone replacement |
| <input type="checkbox"/> Herbs/Supplements | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Birth control pills | |

Any other medications or supplements? _____

Which of the following conditions have you had?

- | | | |
|---|--|--|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostatitis / Peritonitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Herpes Genitalia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Influenza | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Measles / Meningitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neuritis or Neuralgia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Painful/Achy Joints | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Parasites | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Pelvic Infl. Disease | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Yellow Fever |

Any other Major Conditions, or Surgery? ...and When?

Please indicate which one of the following substances you use:

<input type="checkbox"/> Alcohol	How much/often? _____	<input type="checkbox"/> Coffee	How much/often? _____
<input type="checkbox"/> Chewing Tobacco	How much/often? _____	<input type="checkbox"/> Tea	How much/often? _____
<input type="checkbox"/> Cigarettes	How much/often? _____	<input type="checkbox"/> Recreational Drugs	How much/often? _____

Other Substances / Details :

Indicate below, which ailments have affected your relatives. Give ages even if they are/were healthy. Possible ailments include: Alcoholism, Allergies, Arthritis, Asthma, Cancer, Diabetes, Depression, Epilepsy, Frequent Colds, Gonorrhea, Gout, Hay Fever, Heart Disease, Hepatitis, Influenza, Insanity, Nervous Breakdown, Paralysis, Pneumonia, Skin Infections, Syphilis, TB, Ulcers, and others.

	Age if Alive	Age at Death	Ailments:
Father			
Mother			
Brothers			
Sisters			
Maternal Grandfather			
Maternal Grandmother			
Maternal Aunts/Uncles			
Paternal Grandfather			
Paternal Grandmother			
Paternal Aunts/Uncles			

Have you ever been to a Homeopath before? Yes ___ No ___

Do you know what a Homeopath does? Yes ___ No ___

Additional Comments or Concerns...
