Intake form

Patient information

Name: _____
Last Name First name Middle Name

Address: _____
Street address city Province Postal Code

Email: _____

Phone: _____; Mobile: _____

Birth Date (in dd/mm/yyyy): _____; Gender: _____

Birth place (city, state, country):_____

Birth Time: _____

Food preference: Non-vegetarian/ Lacto-ovo (egg-milk) vegetarian/ Lacto-Vegetarian/ Vegan

Habit(tea ,smoking ,alcohol etc.):_____

Marital status: _____;

Occupation-Nature of work: _____

How did you heard about us? _____

Referred by: _____

Please list any medications (prescription or over the counter) you have taken in the last 3 months and reason for taking them (continue on a separate sheet if necessary):

Please enlist any nutritional supplements, herbs, or vitamins (prescription or non-prescription) you have taken in the last 3 months and the reason for taking them (continue on a separate sheet if necessary):

- Have you ever been treated by other alternative healthcare professionals (e.g. Naturopath, Ayurveda etc.) ?_____ (yes/no)
- Have you taken homeopathic remedies before? _____ (yes/no)
- Have you ever had adverse reaction or unusual reaction to vaccines or medications? _____(yes/no)
- Have you ever had any of the following (tick as appropriate)

Abscess	Depression	Hepatitis	Prostatitis
Allergies	Diabetes	Herpes	Sinusitis
Anemia	Eczema	HIV	Skin disease
Appendicitis	Epilepsy	Influenza	Stroke
Arthritis	Frequent colds	Kidney disease	Tonsillitis
Asthma	Gall stones	Malaria	Warts
Cancer	Gonorrhea	Migraine	Others please specify
Chicken-pox	Gout	Moles	Others please specify
Cold sores	Hay fever	Mumps	Others please specify
Crohn's Disease	Headache	Pneumonia	Others please specify
Cyst	Heart disease	PMS	Others please specify

- Have you had any major surgeries, accidents, traumas, or hospitalizations etc.? Please provide date, duration and description.

- Family medical history (mother, father, brothers, sisters, maternal and paternal grand-father and grand-mother, uncles and aunts)

Disease	To whom?	Disease	To whom?
Anemia		Heart problems	
Anxiety		Hemorrhoid	
Arthritis		Kidney disease	
Asthma		Leprosy	
Bleeding tendency		Liver disease	
High Blood Pressure		Paralysis	
Cancer		Tuberculosis	
Convulsion		Urticarial	
Diabetes		Others	
Depression		Others	
Eczema		Others	
epilepsy		Others	

- Chief complaints

Etiology (cause)	Location/Part Affected	Sensation/ feeling in that part	What makes it better	What makes it worse

- How would you describe your current Health? (Tick as appropriate)
  Excellent / Good / Fair / Poor

- I understand that all information disclosed to the practitioner during the homeopathic consultation is confidential and may not be revealed to anyone without written permission except where disclosure is required by law.