



HOMEOPATHIC HEALING

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PATIENT INTAKE FORM

Scheduled Appointment: _____

Patient's Name: _____ Patient's Age: _____

Birthdate: _____ Marital Status: S M D W SEP # of Children: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

How did you hear about me? _____

Present MD and Phone # _____

Do you have insurance coverage for homeopathic medicine?

Homeopathy is a system of medicine that stimulates the body to heal itself. This is accomplished by addressing the imbalances of the body, which lead the patient to their diseased state. To a classical homeopath, the symptoms, which can be physical, emotional or mental, are an expression of the body's attempt to cure and as such can be used to cure homeopathically, curing "like with like". After successful treatment, the patient will find they are healthier and more vital as a whole, because the symptoms were honoured by the body's own attempt to cure, and were not suppressed.

Determining the proper remedy involves investigating and evaluating all of the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time in consultation most effective, I request that you complete the following information form as fully and as accurately as possible. If you have questions, feel free to contact me. Please note that all information you provide is kept in the strictest confidence according to the laws of homeopath/patient confidentiality.

I welcome you to your journey with homeopathic medicine!

Major Complaints In Order of Importance For you

Complaint	Since	Causes

What Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments Or Regimes Are You Currently Following?

Treatment or Regime	Since	Results

Which of the Following Conditions Have You Had?

- | | | | | | | |
|-------------|------------|---------------|----------------|-----------------|--------------|----------------|
| Abscess | Cold Sores | Gout | Kidney Disease | Peritonitis | Sexual Abuse | Typhoid Fever |
| Alcoholism | Depression | Genitalia | Leukamia | Pelvic | Skin Disease | Venereal Warts |
| Allergies | Diabetes | Hayfever | Malaria | Pleury | Sinusitis | Warts |
| Amnesia | Emphysema | Heart Disease | Measles | Pneumonia | Strep Throat | Whooping Cough |
| Arthritis | Epilepsy | Herpes | Miscarriage | Prostatitis | Sunstroke | Worms |
| Asthma | Gallstones | Hepatitis | Mono | Rheumatic Fever | Syphillis | Yellow Fever |
| Cancer | Goitre | Inflammatory | Mumps | Rubella | Tonsilitis | |
| Chicken Pox | Gonorrhea | Influenza | Parasites | Scarlett Fever | Tuberculosis | |

Any Other Major Conditions? _____

What Operations Have You Had?

Operation	When	Complications

What Injuries Have You Had?

Injury	When	Long-Term Effect

Age of first menses: _____ Number of pregnancies: _____

What vaccinations have you had? _____

Any adverse effects from them? _____

Have you lost any weight lately? How Much? _____

What exercise do you do and how much? _____

How Much Of The Following Substances Are You Using?

Tobacco:	Coffee:
Alcohol:	"Recreational Drugs":

Indicate Below, Which Of The Following Ailments, Or Any Other Major Ailments, Have Affected Your Relatives:

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

Relative	Age If Alive	Age At Death	Ailments
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

Are You Currently Under The Care Of Another Physician?

Physician	For What Conditions	Treatments

Have You Been Treated With Homeopathy Before? _____

For What Conditions? _____ Remedies? _____