

**HOMEOPATHIC TREATMENT**

**ADULT INTAKE FORM**

**Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**DATE OF VISIT:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**POSTAL CODE:** \_\_\_\_\_ **PHONE: WORK** \_\_\_\_\_ **HOME** \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**WHAT ARE YOUR MAIN HEALTH CONCERNS.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:**

- |                        |                            |                                    |
|------------------------|----------------------------|------------------------------------|
| Jaundice (yellow skin) | lack of energy             | ulcers                             |
| arthritis              | insomnia                   | chronic fatigue                    |
| nervousness            | constipation/diarrhea      | malaria or other tropical diseases |
| convulsions/epilepsy   | heart problems             | history of venereal disease        |
| skin rashes            | vision problems            | herpes , shingles                  |
| asthma                 | warts (plantar, genital)   | vaccination side-effects           |
| ear infections         | allergies                  | recurrent bladder infections       |
| dentition problems     | scarlet or rheumatic fever | candida (yeast infections)         |

**OTHER PROBLEMS NOT LISTED:** .....

**PAST ILLNESSES**.....  
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**PAST OPERATIONS**

- 1..... **when**.....
- 2..... **when**.....
- 3..... **when**.....

**DO YOU USE THE FOLLOWING :**

**Cigarettes....., Alcohol....., Recreational drugs....., frequency of use.**

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**Medications/Vitamins/Supplements:**

**Please**

**list.....**

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**FAMILY ILLNESSES:**

**PLEASE INDICATE ANY ILLNESSES IN YOUR PARENTS OR SIBLINGS.**

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