HOMEOPATHY LIFE CLINIC

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**_____

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	depression
arthritis	insomnia	sensitivity to meds
nervousness/panic attacks	constipation/diarrhea	sore throats (Strep)
convulsions/epilepsy	heart problems	alcoholism
skin rashes	ulcers	drug addiction
herpes, shingles (zoster)	chronic fatigue	digestive problems
asthma	malaria or other tropical diseases	sinusitis
warts (plantar,genital etc)	history of venereal disease (std's)	miscarriage
vaccination side-effects	vision problems (cataracts etc)	hot flashes-menopause
ear infections	candida (yeast infections)	hemorrhoids
allergies	fibromyalgia	diverticulitis
recurrent bladder infections	trigeminal neuralgia	polyps, cysts
dentition problems	tuberculosis history (family)	diabetes
scarlet or rheumatic fever	liver problems	weight problems

OTHER PROBLEMS NOT LISTED:

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….....

PAST ILLNESSES (childhood,teens)
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PAST SURGICAL OPERATIONS

1.....when.....
2.....when.....
3……...when…….

DO YOU USE THE FOLLOWING :

Cigarettes....., Alcohol....., Recreational drugs....., plus 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 AND SIBLINGS:

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