



**Kimberly Hahn, BSc, DHMS, RAc, HD**

7626 Doner Drive, Washago ON L0K 2B0  
 705-689-6395 phone/text 705-689-9001 fax  
[www.greenrivernaturalhealth.com](http://www.greenrivernaturalhealth.com)  
[kim@greenrivernaturalhealth.com](mailto:kim@greenrivernaturalhealth.com)

## **Adult Homeopathic Intake Form**

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

(Please Print)			
Today's date:			
<b>PATIENT INFORMATION</b>			
Last name:	q Mr. q Mrs.	q Miss q Ms.	Marital status :
First name:	Date of birth:	Age:	Email address:
Street address:	Contact Numbers: (h) (c)	Number of children	
City:	Province:	Postal Code:	
Occupation:	Employer:	Work phone no.:	
Referred by: (check one)	q Centre staff	q Family	qHospital
	q Insurance plan	q Dr.	qFriend
			qClose to home or work
Name and phone no. of Family Physician:			
Name and phone no. of previous Homeopath:			
<b>IN CASE OF EMERGENCY</b>			
Emergency contact person:	Home phone no.:	Work phone no.:	
<b>VITAL STATISTICS</b>			

<b>HEIGHT:</b>	<b>WEIGHT:</b>	<b>B.P.:</b>	<b>PULSE:</b>
----------------	----------------	--------------	---------------

What is your main health concern, and when did it start?

---

Was it preceded by an event, accident or mental upset? (ie. shock, worry, dietary, overexertion, weather?)

---

Does anything make it better?

Worse?

---

Do you have any other health concerns? Please list in order of importance for you, and the date of onset.

---



---

Please check  if you have ever had any of these conditions:

- |                                       |                                         |                                                      |
|---------------------------------------|-----------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Abscesses    | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Heart trouble  | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Anaemia      | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Prostate disease            |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Rheumatic fever             |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Herpes         | <input type="checkbox"/> Skin disease                |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Strep throat                |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Sinusitis                   |
| <input type="checkbox"/> Chicken pox  | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Cold sores   | <input type="checkbox"/> Leukemia       | <input type="checkbox"/> Gout                        |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Syphilis                    |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Malaria        | <input type="checkbox"/> Tonsillitis                 |
| <input type="checkbox"/> Eczema       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Venereal warts              |
| <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Warts                       |
| <input type="checkbox"/> Gall stones  | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Whooping cough              |
| <input type="checkbox"/> Goitre       | <input type="checkbox"/> Nosebleeds     | <input type="checkbox"/> Worms                       |
| <input type="checkbox"/> Gonorrhoea   | <input type="checkbox"/> Parasites      |                                                      |

Others? \_\_\_\_\_

Indicate your use of the following:

	Per day	Per week	Per month
Tobacco			
Alcohol			
Coffee			
Recreational Drugs			

What vaccinations have you had? List any reactions.

What exercise do you do and how much?

List any treatments, medicines, supplements, homeopathic remedies you are taking.

Treatment or Medicine	When and for how long?	Effect on you?
Any major surgeries?	When?	Complications?
Major injuries?	When?	Complications or long-term effects?

**FAMILY HISTORY**: Please indicate what ailments affect(ed) your family. These can include:

- |                                      |                                         |                                                |
|--------------------------------------|-----------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Skin diseases         |
| <input type="checkbox"/> Alcoholism  | <input type="checkbox"/> Gonorrhoea     | <input type="checkbox"/> Syphilis              |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Others* Specify below |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Mental illness |                                                |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Pneumonia      |                                                |

\* \_\_\_\_\_  
\_\_\_\_\_

Relationship	Current Age	Age at Death	Cause of Death	Disease(s)
Mother				
Maternal Grandfather				
Maternal				

Grandmother				
Father				
Paternal Grandfather				
Paternal Grandmother				
Sister(s)				
Brother(s)				

**SYSTEMS REVIEW:** Please check with a  $\sqrt{\quad}$  if you are currently suffering from, or with a P if you have suffered from any of the following disorders in the past:

**Skin:**

- |                                                 |                                  |                                         |                                       |
|-------------------------------------------------|----------------------------------|-----------------------------------------|---------------------------------------|
| <input type="checkbox"/> rashes                 | <input type="checkbox"/> eczema  | <input type="checkbox"/> hives          | <input type="checkbox"/> acne         |
| <input type="checkbox"/> boils                  | <input type="checkbox"/> itching | <input type="checkbox"/> lumps          | <input type="checkbox"/> dry hair     |
| <input type="checkbox"/> dryness                | <input type="checkbox"/> scaling | <input type="checkbox"/> moles          | <input type="checkbox"/> warts        |
| <input type="checkbox"/> falling/ thinning hair |                                  | <input type="checkbox"/> colour changes | <input type="checkbox"/> nail changes |

**Head:**

- |                                        |                                    |                                  |                                    |
|----------------------------------------|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> headache      | <input type="checkbox"/> dizziness | <input type="checkbox"/> vertigo | <input type="checkbox"/> migraines |
| <input type="checkbox"/> head injuries |                                    |                                  |                                    |

**Eyes:**

- |                                        |                                    |                                          |                                   |
|----------------------------------------|------------------------------------|------------------------------------------|-----------------------------------|
| <input type="checkbox"/> eye pain      | <input type="checkbox"/> tearing   | <input type="checkbox"/> dryness         | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> double vision | <input type="checkbox"/> cataracts | <input type="checkbox"/> blurring        | <input type="checkbox"/> itching  |
| <input type="checkbox"/> redness       | <input type="checkbox"/> discharge | <input type="checkbox"/> impaired vision |                                   |

**Ears:**

- |                                    |                                     |                                           |                                  |
|------------------------------------|-------------------------------------|-------------------------------------------|----------------------------------|
| <input type="checkbox"/> ringing   | <input type="checkbox"/> buzzing    | <input type="checkbox"/> earache          | <input type="checkbox"/> redness |
| <input type="checkbox"/> discharge | <input type="checkbox"/> infections | <input type="checkbox"/> impaired hearing |                                  |

**Nose/sinuses:**

- |                                         |                                        |                                          |                                      |
|-----------------------------------------|----------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> stuffiness    | <input type="checkbox"/> hay fever       | <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> obstruction    | <input type="checkbox"/> loss of smell | <input type="checkbox"/> nasal discharge |                                      |
| <input type="checkbox"/> sinus problems |                                        |                                          |                                      |

**Mouth and throat:**

- |                                        |                                        |                                          |                                        |
|----------------------------------------|----------------------------------------|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> sore throats  | <input type="checkbox"/> cankers       | <input type="checkbox"/> dry lips        | <input type="checkbox"/> bleeding gums |
| <input type="checkbox"/> receding gums | <input type="checkbox"/> loss of taste | <input type="checkbox"/> dental cavities |                                        |

**Neck:**

- |                                            |                                                |                                         |
|--------------------------------------------|------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> lumps             | <input type="checkbox"/> goitre                | <input type="checkbox"/> swollen glands |
| <input type="checkbox"/> pain or stiffness | <input type="checkbox"/> difficulty swallowing |                                         |

**Respiratory:**

- |                                 |                                     |                                         |                                    |
|---------------------------------|-------------------------------------|-----------------------------------------|------------------------------------|
| <input type="checkbox"/> cough  | <input type="checkbox"/> sputum     | <input type="checkbox"/> spitting blood | <input type="checkbox"/> wheezing  |
| <input type="checkbox"/> asthma | <input type="checkbox"/> bronchitis | <input type="checkbox"/> pneumonia      | <input type="checkbox"/> emphysema |

\_\_\_ difficulty breathing \_\_\_ shortness of breath \_\_\_ allergies

**Cardiovascular:**

\_\_\_ palpitations \_\_\_ chest pain on exertion \_\_\_ blueness of lips \_\_\_ swelling of ankles  
\_\_\_ high blood pressure \_\_\_ low blood pressure

**Gastrointestinal:**

\_\_\_ heartburn \_\_\_ nausea \_\_\_ vomiting \_\_\_ constipation  
\_\_\_ diarrhea \_\_\_ gas \_\_\_ belching \_\_\_ bloating  
\_\_\_ abdominal pain \_\_\_ lack of appetite \_\_\_ ineffectual urging \_\_\_ haemorrhoids  
\_\_\_ indigestion \_\_\_ food allergies

**Musculoskeletal:**

\_\_\_ pain in joints \_\_\_ swollen joints \_\_\_ stiffness in joints \_\_\_ broken bones  
\_\_\_ muscle spasms \_\_\_ cramps  
\_\_\_ muscle twitching

**Peripheral vascular:**

\_\_\_ deep leg pain \_\_\_ cold hands \_\_\_ cold feet \_\_\_ varicose veins  
\_\_\_ ulcers \_\_\_ extremity numbness \_\_\_ extremity coldness \_\_\_ extremity swelling

**Neurological:**

\_\_\_ fainting \_\_\_ convulsions \_\_\_ paralysis \_\_\_ tremors  
\_\_\_ numbness \_\_\_ tingling \_\_\_ weakness \_\_\_ involuntary movements  
\_\_\_ loss of memory \_\_\_ difficulty concentrating \_\_\_ loss of balance  
\_\_\_ difficulty initiating movements \_\_\_ speech problems

**Endocrine:**

\_\_\_ cold intolerance \_\_\_ excess thirst \_\_\_ excess hunger \_\_\_ sudden weight gain  
\_\_\_ sudden weight loss \_\_\_ heat intolerance \_\_\_ excess sweating

**Reproductive system – FEMALES:**

\_\_\_ menstrual problems \_\_\_ sexual difficulties \_\_\_ pain/dryness during intercourse  
\_\_\_ problems achieving orgasm \_\_\_ difficulties conceiving or carrying a pregnancy to term  
\_\_\_ venereal disease Age of first menses \_\_\_\_\_ Date of last menses \_\_\_\_\_

**Reproductive system – MALES:**

\_\_\_ testicular pain \_\_\_ testicular masses \_\_\_ abnormal penile discharges \_\_\_ sexual difficulties  
\_\_\_ erectile difficulties \_\_\_ fertility difficulties \_\_\_ enlarged prostate \_\_\_ venereal disease