Green River Natural Health

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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:			
PATIENT INFORMATION			
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 Insurance plan	q Family q Dr.	qHospital qFriend	qClose to home or work qWebsite
Name and phone no. of Family Physician:			
Name and phone no. of previous Homeopath:			
IN CASE OF EMERGENCY			
Emergency contact person:	Home phone no.:		Work phone no.:
VITAL STATISTICS			

HEIGHT:	WEIGHT:	B.P.:	PULSE:

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:

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

❑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:

❑Alzheimer's
❑Alcoholism
❑Asthma
❑Arthritis
❑Cancer
❑Diabetes
❑Depression
❑Epilepsy
❑Gonorrhoea
❑Hypertension
❑Heart disease
❑Hepatitis
❑Mental illness
❑Pneumonia
❑Skin diseases
❑Syphilis
❑Tuberculosis
❑Ulcers
❑Others* Specify below

*_____
_____

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 √ if you are currently suffering from, or with a P if you have suffered from any of the following disorders in the past:

Skin:

____ rashes ___ eczema ___ hives ___ acne
___ boils ___ itching ___ lumps ___ dry hair
___ dryness ___ scaling ___ moles ___ warts
___ falling/ thinning hair ___ colour changes ___ nail changes

Head:

___ headache ___ dizziness ___ vertigo ___ migraines
___ head injuries

Eyes:

___ eye pain ___ tearing ___ dryness ___ glaucoma
___ double vision ___ cataracts ___ blurring ___ itching
___ redness ___ discharge ___ impaired vision

Ears:

___ ringing ___ buzzing ___ earache ___redness
___ discharge ___ infections ___ impaired hearing

Nose/sinuses:

___ frequent colds ___ stuffiness ___ hay fever ___ nose bleeds
___ obstruction ___ loss of smell ___ nasal discharge
___ sinus problems

Mouth and throat:

___ sore throats ___ cankers ___ dry lips ___ bleeding gums
___ receding gums ___ loss of taste ___ dental cavities

Neck:

___ lumps ___ goitre ___ swollen glands
___ pain or stiffness ___ difficulty swallowing

Respiratory:

___ cough ___ sputum ___spitting blood ___ wheezing
___ asthma ___ bronchitis ___ pneumonia ___ 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