Patient Information Date: _____

Name: _____
Address: _____
(street) (city) (province) (postal code)

Phone #: Home: _____ Work: _____ Cell: _____

Best time and phone to contact you:_____

Occupation: _____ E-mail address: _____
Referred by: _____
Have you seen a **HOMEOPATH** previously? yes no

Birth date: Day _____ Month _____ Year _____ Age _____ years old
Gender: male female
Status: Common- law Married Separated Divorced Widowed
Name of spouse: _____
Children: _____ Names/ages: _____
_____

Emergency contact name: _____ Phone #: _____
Relationship: _____ Phone #: Home _____
Work _____

Primary Concern (Explain briefly): _____
How long have you had this problem? _____
Have you been given a diagnosis? _____
To what extent does this problem affect your daily life? (work, sleep, eating, ect.)_____
_____
Please list any treatments currently or previously used for this condition and their results:
_____
_____
Other Concerns: _____

Past Medical History

Please list previous medical procedures, surgereris, hospitalizations and major traumas (included auto accidents, falls, ect.)

Approximate date	Surgery/ hospitalizations/procedures/injuries

Known food allergies/intolerance: _____

_____

Known environmental allergies/sensitivities: _____

_____

Current prescription medication (e.g. Prozac, atenolol, ect.) **non-prescription medication**(e.g., aspirin, Tylenol, ibuprofen) and/**or health supplements** (e.g. vitamins, minerals, herbs): *please list the medication and/or supplements that you are currently taking with dosages.*

Name of medication	dose	# times/day	duration -length of time on medication

Family Medication History

	Present age	General health	Specific diseases
Mother			
Father			
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			
Grandparent 1t			
Grandparent 2			
Grandparent 3			
Grandparent 4			
Please list any significant diseases prevalent in your family:			

General Review

Height ____ Weight _____ Weight 1 year ago ____ Max weight/when ____
Average energy level during the day (0=none 10=max)____
Best time of day for energy_____ Worst time of Day for energy_____

Please check any of the conditions you have had previously or have currently

□ Poor appetite □ fever □strong thirst
□ Change in appetite □ chills □ Poor balance
□ Weight loss □ night sweats □ Problems getting to sleep
□ Weight gain □ bruise easily □problems staying asleep

Please check any of the conditions you have had previously or have currently

□ Alcoholism □ Bronchitis □ Emphysema □Miscarriage
□ Anemia □ Cancer □ Epilepsy □ Pneumonia
□Anorexia/bulimia □ chicken pox □ gout □Rheumatic fever
□□Appendicitis □ cold sores □ heart attack/angina□ Scarlet fever
□Arteriosclerosis □Crohn's/Colitis □ Hepatitis □ Seizures
□Arthritis □Eczema □Diabetes □ Thyroid disease

How many cups of each do you drink: Coffee____/d tea____/d cola___/d
alcohol____/w
Do you smoke? How many per day_____
Do you use recreational drugs _____#times/week

List your stress factors (Physical chemical psychological)

Work _____
Home _____

_____ _____
Signature Date