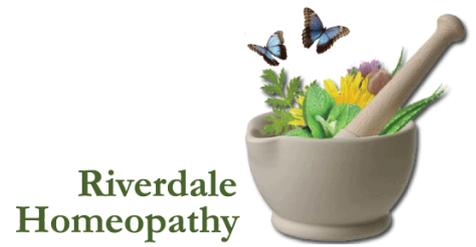


**Riverdale Homeopathic Clinic**

**Intake Form**



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our newsletter? Yes \_\_\_ No \_\_\_

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

***Major Complaints***

Complaint	Since	Cause(s)

***Current Medications/Supplements***

Medication/Supplement	Since	Reasons

***Other Treatments/Regimes Currently Following***

Treatment/Regime	Since	Cause(s)

Have you been treated with Homeopathy before? \_\_\_\_\_ If yes who was your practitioner?

Practitioner: \_\_\_\_\_ When: \_\_\_\_\_

**What homeopathic remedies have you taken?**

Remedy	When	Response

Are you currently under the care of a physician (s)? Yes No

Physician: \_\_\_\_\_ Condition(s): \_\_\_\_\_

Other Practitioners?

Name: \_\_\_\_\_ Phone number \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_

**Please Indicate Which of the Following Conditions You Have / Had**

Abscesses	Cold Sores	Hay fever	Malaria	Rubella	Tuberculosis
Alcoholism	Depression	Heart disease	Mononucleosis	Scarlet fever	Typhoid fever
Allergies	Diabetes	Hepatitis	Mumps	Sexual abuse	Venereal warts
Asthma	Epilepsy	Herpes	Measles	Skin disease	Warts
Arthritis	Gallstones	Influenza	Parasites	Sinusitis	Whooping cough
Cancer	Gonorrhea	Kidney disease	Pneumonia	Syphilis	

Do you have any preceding conditions which are worse than usual or that you never fully recovered from?

Which ones?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any events after which you have never felt well?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What surgeries have you had?**

Surgery	When	Complications?

**What injuries have you had?**

Injury	When	Long term effects

How often do you consume the following substances:

Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Drugs (non-prescription) \_\_\_\_\_

Have you lost/gained any weight lately? How much? \_\_\_\_\_

Do you exercise? How often and what do you do? \_\_\_\_\_

Age of first menstruation: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Have you ever taken birth control? \_\_\_\_\_

Do you or have you ever had amalgam fillings (silver fillings): \_\_\_\_\_

**Please Indicate (☐) Which of the Following Conditions have affected your relatives:**

Alcoholism	☐	Allergies	☐	Arthritis	☐	Asthma	☐
Cancer	☐	Colitis	☐	Depression	☐	Diabetes	☐
Epilepsy	☐	Gonorrhea	☐	Heart Disease	☐	Pneumonia	☐
Mental Illness	☐	Skin Disease	☐	Syphilis	☐	Tuberculosis	☐

Relative	Age (if alive)	Age at Death	Illnesses (ex. Diabetes, cancer, mental illness)
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunt/Uncle			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt/Uncle			