Riverdale Homeopathic Clinic

Intake Form

Riverdale Homeopathy

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			