Homeopathic Intake Form

Homeopathic consultation is facilitated when there is a complete picture of the individual's mental, emotional and physical states of health. This includes symptoms that affect both physical sensations (what does it feel like), and function (how it impacts you) and what ameliorates or aggravates each symptom.

Date: _____

Name _____ Age___ Birth date _____Sex ___

Address_____

City_____ Province _____ Postal Code_____

Phone (home)_____(work)_____ (cell)_____

E-mail

_____

Would you like to be added on our mailing list to receive special event notices? Y N

Occupation _____Full-time/Part-time _____Retired____

Education_____

Married ____ Separated _____ Divorced_____ Widowed _____Single_____

Are you familiar with or have you ever had Homeopathic treatment? Y N

If yes, what remedies have you taken and what remedies have helped?

_____

_____.

In your opinion, what are your most important health problems? List as many as you can, in order of importance:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Past Medical History:

When did your complaint or ailment begin?_____

_____

_____

What do you think causes or has caused your ailment or complaint?

_____

_____

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Harmony House WELLNESS

Have you had an experience (traumatic, illness, vaccine or other) that did or still affects you deeply? Explain. _____
_____

The general state of my health has been:
Excellent____ Good ____Fair ____ Poor ____

What childhood illnesses have you had?

____ Rubella (3 day-measles)	____ Mumps	____ Chickenpox
____ Measles (2 weeks)	____ Whooping Cough	____ Asthma
____ Scarlet Fever	____ Rheumatic Fever	

Others: _____

What vaccinations have you had?

_____ Mumps (individual)	_____ Chickenpox
_____ Measles (individual)	_____ Tetanus (individual)
_____ Rubella (individual)	_____ Pertussis (individual)
_____ MMR	_____ DPT
_____ Influenza (flu)	_____ Diphtheria (individual)
_____ Hepatitis	_____ HPV

_____ Other _____
Any adverse reaction to vaccines? Explain_____

Your Health History

Please check which of the following you have experienced or are suffering from now:

Abortion	Alcoholism	Allergies	Anaemia	Appendicitis
Asthma	Cancer	Chicken Pox	Cold Sores	Depression
Diabetes	Eczema	Epilepsy	Emphysema	Gall Stones
Goiter	Gonorrhoea	Gout	Hay Fever	Heart Trouble
Hypertension	Hepatitis	Herpes	Inflammation	Influenza
Jaundice	Kidney Disease	Pneumonia	Leukemia	Liver Disease
Malaria	Measles	Mental Problems	Miscarriage	Mononucleosis
Mumps	Nosebleeds	Parasites	Tonsillitis	Prostatitis
Psoriasis	Rheumatic Fever	Sexual Abuse	Skin Disease	Strep Throat
Sinusitis	Stroke	Syphilis	Thyroid Problems	Tuberculosis
Urticaria	Venereal	Warts	Whooping Cough	Worms
Yellow Fever	Other:_____			

Hospitalizations: List as best as you can.

Type of illness/operation	Date:	Where:
_____	_____	_____
_____	_____	_____

Please check which of the following substances you are currently using:

Alcohol	How Much?	Pain Killer	How Much?
Chewing Tobacco	How Much?	Recreational Drugs	How Much?
Cigarettes	How Much?	Sleeping Pills	How Much?
Coffee	How Much?	Supplements/Herbs	How Much?
Laxatives/Purgatives	How Much?	Tea (incl. herbal)	How Much?

Other therapies _____

Are you allergic to any drugs (penicillin, etc.)? _____
Are you allergic to foods or other substances? _____
What happens when you have an "allergy attack" or "sensitivity reaction"?
_____

Family History

Please list ages, and if deceased, what was the cause and at what age:

Relation	Living	Died	Cause	Age
Your Mother				
Your Father				
Your Brother (s)				
Your Sister (s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Has any blood relative had any of the following?

Yes	No	D.K. (Don't Know)		Yes	No	D.K.	
___	___	___	Allergies	___	___	___	Gout
___	___	___	Anemia	___	___	___	Hay Fever
___	___	___	Arthritis	___	___	___	Heart Attack
___	___	___	Asthma	___	___	___	High Blood Pressure
___	___	___	Bleeding	___	___	___	Seizure/Epilepsy
___	___	___	Cancer	___	___	___	Sickle Cell Anemia
___	___	___	Diabetes	___	___	___	Stroke
___	___	___	Depression	___	___	___	Thyroid Trouble
___	___	___	Eczema	___	___	___	Tuberculosis
___	___	___	Glaucoma	___	___	____	STD

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Symptoms: Please mark 1 (mild), 2 (moderate), 3 (severe) if any of the following apply to you NOW or in the PAST.

Now Past

Skin

____ ____ skin: rough, dry, scaly, bumpy, itchy (circle)
____ ____ rashes, warts, moles, cysts (circle)
____ ____ light or dark patches of skin (circle)
____ ____ increased hair growth in unusual places
____ ____ pimples
____ ____ color changes in nails
____ ____ hives
____ ____ loss of hair
____ ____ ridges, pits or spots on nails
____ ____ infections, fungal symptoms

Blood, Lymph, Immune

____ ____ Swollen or painful lymph nodes
____ ____ Difficulty stopping bleeding
____ ____ Bruise easily

Now Past

____ ____ Wounds heal slowly
____ ____ Swollen glands

Endocrine

____ ____ Excessive hair growth
____ ____ Cold hands or feet
____ ____ Weakness
____ ____ Can't stand cold
____ ____ Chronic fatigue

____ ____ Prefer cold weather
____ ____ Unexplained thirst
____ ____ Increased hunger
____ ____ Can't stand heat
____ ____ Profuse sweating

Head

____ ____ Dizziness
____ ____ Severe headaches
____ ____ Seizures/tics/spasms

____ ____ Double vision
____ ____ Fainting spells
____ ____ Injuries

Eyes

____ ____ Infections
____ ____ Blurred vision
____ ____ Sensitive to light

____ ____ Near/far sighted
____ ____ Floaters
____ ____ Injuries

Ears

____ ____ Discharge from ears
____ ____ Pain in ears
____ ____ Hearing trouble

____ ____ Infections
____ ____ Injuries
____ ____ Noises in ears

Nose

____ ____ Nose bleeds
____ ____ Sinus problems

____ ____ Injury
____ ____ Loss of smell

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____ ____ Obstruction - difficulty breathing through nose

Now	Past		Now	Past	
Mouth					
____	____	Sore mouth or tongue	____	____	Bad breath
____	____	Infections	____	____	Gum disease
____	____	Loss of teeth	____	____	Speech difficulties
Throat					
____	____	Persistent hoarseness	____	____	Pain
____	____	Difficulty swallowing	____	____	Infections
____	____	Loss of voice	____	____	Swelling
Neck					
____	____	Stiffness	____	____	Swelling
____	____	Injuries			
Respiratory					
____	____	Unexplained fever	____	____	Night sweats
____	____	Chest pain	____	____	Shortness of breath
____	____	Wheezing	____	____	Daily cough
____	____	Infections	____	____	Difficulty breathing
____	____	Difficulty breathing at night (wakes you up)			
Cardiovascular					
____	____	Chest pain when walking	____	____	Varicose veins
____	____	Ankle-swelling	____	____	Hypertension (HBP)
____	____	Shortness of breath	____	____	Leg pain (walking)
____	____	Heart palpitations (fluttering, pressure, skipping, rapid beat)			
Digestive System					
____	____	Frequent or severe symptoms	____	____	Vomiting, nausea
____	____	Blood in stools	____	____	Hemorrhoids
____	____	Change in bowel movements	____	____	Black stools
____	____	Heartburn	____	____	Vomiting blood
____	____	Indigestion	____	____	Anal itching
____	____	Excessive belching	____	____	Yellow jaundice
____	____	Stomach pain	____	____	Diff. swallowing
____	____	Distress from fats or greasy foods			
____	____	Stools yellow, clay-colored, foul odored, has undigested food			
____	____	Bad breath, bad taste in mouth; body odor (including feet)			
____	____	Indigestion after meals (fullness, bloating, sourness, etc.)			
____	____	Heavy, full feeling after eating			

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____ ____ History of constipation or diarrhea
____ ____ Excessive lower bowel gas
____ ____ Stomach pain occurs 5 or 6 hours after eating
____ ____ History of constipation or diarrhea
____ ____ Indigestion occurs immediately after eating
____ ____ Nervousness, shaky feelings, headaches, relieved by eating
____ ____ Irritable if late for meal, miss meal, or before eating breakfast
____ ____ Sudden, strong craving for sweets or alcohol

Now	Past		Now	Past	
____	____	Wake up at night feeling hungry	____	____	Overweight
____	____	Loss of appetite	____	____	Sudden weight loss
____	____	Sudden weight gain	____	____	Infection
____	____	Injury			

____ ____ Sleepy during the day? When? _____

How often do you have bowel movements?_____
Do you strain at stool? _____. Have you had a change of appetite? _____Increase / decrease?
Do you snack?_____. On what? _____
_____
What foods, condiments, or any other substances (i.e. chocolate, ice-cream, mustard, sour, spicy, chalk etc.) do you crave? _____
Are you repelled by, or do you dislike any foods?
_____
Are there any foods that trouble or aggravate or do not agree with you? In what way?
_____
Are you thirsty? ____ For hot drinks _____ For cold drinks_____
Ice in your drinks ____ Do you like to chew ice? ____

Urogenital System

Now	Past		Now	Past	
____	____	Frequent urination	____	____	Painful urination
____	____	Night urination	____	____	Trouble starting urine
____	____	Trouble holding	____	____	Frequent urging with scant urination

Male Problems

____ ____ Difficulty achieving or maintaining an erection
____ ____ Lumps, swelling or pain in testicles

____	____	Any prostate problems	____	____	Discharge from penis
____	____	Painful erection	____	____	Difficulty with ejaculation
____	____	Infection	____	____	Infertility
____	____	Injury			

Female Problems

____ ____ Menstrual flow is excessive/absent (circle)
____ ____ Bleeding or spotting between periods
____ ____ Pain before, during/after periods (circle)
____ ____ Discharge from vagina
____ ____ No lubrication when aroused
____ ____ Sex is painful
____ ____ Infection
____ ____ Lumps in breast
____ ____ Premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, (circle) other…
____ ____ Difficulty feeling sexually aroused
____ ____ Never or seldom have orgasms
____ ____ Pelvic pain
____ ____ Infertility

Spine and Extremities

Now Past Now Past

____ ____ Joint pain, swelling, stiffness, tingling, numbness
Where? _____
____ ____ Muscle cramps
____ ____ Burning soles of feet
____ ____ Injuries
____ ____ Backaches
____ ____ Unusual redness of palms of hands
____ ____ Other

Have you ever had arthritis? _____
Where _____What kind _____

Nervous System

Now Past

____ ____ Loss of balance
____ ____ Convulsions
____ ____ Lack of strength (seizures, stiffness)
____ ____ Tremor (shaking, involuntary movements, tics, spasms)
____ ____ Paralysis
____ ____ Numbness

General

Are you a warm or chilly person? _____
Are you sensitive to changes in weather? _____ sun _____ drafts _____wind ___ noise ___ ordered environment _____ other _____
_____

When in bed, if you feel warm, what part of your body would you tend to uncover first? _____.
Do you usually dream? _____. Are there specific dreams or recurring themes to your dreams?
If so, what?_____
_____

Mental/Emotional

Now	Past		Now	Past	
____	____	Restlessness	____	____	Anxiety
____	____	Excessive worry	____	____	Nervousness
____	____	Memory trouble	____	____	Trouble concentrating
____	____	Depression	____	____	Crying spells
____	____	Trouble sleeping	____	____	Nightmares
____	____	Trouble getting along with people	____	____	Easily angered
____	____	Feelings of worthlessness	____	____	Mood swings
____	____	Suicidal thoughts	____	____	Fearful
____	____	Excess stress	____	____	Always put others' interests before mine
____	____	See things that others don't	____	____	Hear voices
____	____	Think others want to hurt you	____	____	Don't know how to relieve stress

____ ____ Loss of someone dear through death or separation
____ ____ Is order important to your surroundings?
____ ____Are you generally late for appointments?
____ ____ Do you tend to leave things undone until the last minute
____ ____ Peculiar sensations? What? _____
Where?_____

How do symptoms of stress show up in you (physically/emotionally)?
_____
_____
What are your triggers for stress_____
_____
_____
How do you alleviate stress?_____
_____
_____
Is there anything else you wish to add?
_____
_____
_____

Homeopathic Disclosure & Informed Consent
I understand that a homeopathic remedy may be given with this consultation or be suggested for purchase at a store of my choosing.
If given at the time of consult and needed to be repeated before the next consult, a $10.00 remedy fee (plus shipping if necessary) will be charged.
I confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.
I understand that a block of time has been set aside for my private appointment and that a 24-hour notification is required if I must cancel.
I understand that there is a fee of one consult hour ($80.00) for appointments canceled less than 24 hours in advance.

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I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment.
I understand that phone consultations will be billed at the usual hourly rate.
I understand that current fees for single consultations are as follows, but that there may be changes in the fee structure in the future. (Homeoprophylaxis Program prices differ.)
My fee and approximate length of time of appointments:

- Adult New Patient- 2 hours $220.00
- Child New Patient- 1.5 hours $185.00
- Follow up visit- 1 hour $90.00
- Telephone Consults- 15 minute (minimum) $25.00

At this time tax are included

Homeopathy is considered to be an alternative/preventative system of health care and is not intended to be a substitute for allopathic or traditional medicine.
The therapy and information offered should not be construed by you, the client, or any family, friends or caregivers to be a medical diagnosis of any disease or injury.
You should consult with your physician for any serious medical condition and further, you should get at least two medical opinions for such condition.
While Christine Moran DHMHS has had extensive training in the science and art of Homeopathy and Health Science, she is neither a medical doctor nor a licensed physician.
I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Signature: _____. Date: _____
If patient is under 18 years, parental signature is required.

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WELLNESS