

GUIA VITA HOMEOPATHIC CLINIC

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ADULT HOMEOPATHIC INTAKE FORM

Date:	Referred by:	
Name:		
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
Email: _____		
Would you like to be added in my mailing list to receive special offers and events notices? Yes _____ No _____		
Marital Status:	Single _____	Married _____ Divorced _____ Widowed _____
Date of Birth:	Age:	Sex: F ___ M ___
Height:	Weight:	
Occupation:	Employer:	
Insurance Plan:		
Name and phone of Family Physician:		
Name and phone of previous Homeopath:		
Emergency contact person:	Relationship:	
Phone:		

What are your main concerns in order of priority?

Since when?

Are you currently taking any medications or supplements? For how long?

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

Alcohol _____

Painkillers _____

Cigarettes _____

Recreational drugs _____

Coffee _____

Sleeping Pills _____

Laxatives _____

Tea _____

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

- Abortion
- Alcoholism
- Allergies
- Anemia
- Appendicitis
- Asthma
- Cancer
- Chicken Pox
- Cold Sores
- Depression
- Diabetes
- Eczema
- Epilepsy
- Emphysema
- Gall Stones

- Hypertension
- Hepatitis
- Herpes
- Influenza
- Jaundice
- Kidney disease
- Pneumonia
- Leukemia
- Liver Disease
- Malaria
- Measles
- Mental problems
- Miscarriage
- Mononucleosis
- Mumps

- Rheumatic Fever
- Sexual Abuse
- Skin Disease
- Strep Throat
- Sinusitis
- Stroke
- Syphilis
- Thyroid problems
- Tuberculosis
- Urticaria
- Venereal warts
- Warts
- Whooping cough
- Worms
- Yellow Fever

- Goiter
- Gonorrhea
- Gout
- Hay Fever
- Heart Trouble

- Nosebleeds
- Parasites
- Tonsillitis
- Prostatitis
- Psoriasis

Other:

Please list surgeries and/or injuries you had in the past.

Have you had adverse reactions in any vaccinations?

Please check if you have any of the following ailments in your family history:

- Alzheimer's
- Alcoholism
- Cancer
- Diabetes

- Depression
- Gonorrhea
- Hypertension
- Heart Disease

- Hepatitis
- Mental illness
- Skin Disease
- Tuberculosis

Other: _____

Relationship	Age	If deceased, age at death	Cause of Death	Diseases
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister(s)				
Brother(s)				
Aunt(s)				
Uncle(s)				
Children				