

Name

Birthday

Mailing Address

City

Zip

UPS Address

City

Zip

Home phone

Work phone

Marital status

Cell

Email address

Occupation

Who referred you?

Prior Homeopathic treatment?

By whom?

Date last seen

IN EVENT OF EMERGENCY PLEASE NOTIFY

Name

Phone

MEMBERS OF YOUR HOUSEHOLD

| Name | Age | Relationship |
|------|-----|--------------|
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ALLERGIES (please list all known or suspected drug sensitivities as well as environmental allergies)

MEDICATIONS, VITAMINS and SUPPLEMENTS (include nonprescription and herbs)

| Name | Dosage | Frequency |
|------|--------|-----------|
| | | |
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HEALTH HABITS

How many times each week do you exercise for 20 minutes or more?

How do you exercise?

Do you smoke cigarettes?

If so, how many each day?

At what age did you start?

Do you drink alcohol?

How much each week?

Are you concerned about your use of alcohol?

Do you use other recreational drugs?

Are you concerned about your use of those drugs?

Do you drink coffee?

How much?

Do you eat a well balanced breakfast?

Do you wear seatbelts every time you are in an automobile?

Do you set aside enough time for adequate relaxation?

Are you a careful driver?

How do you relax?

ARE YOU EXPOSED TO ANY TOXIC SUBSTANCES?

(Please provide details regarding those exposures that concern you)

WHAT HEALTH PROBLEMS ARE YOU PARTICULARLY CONCERNED ABOUT?

WHAT RECENT LOSSES OR UNUSUAL STRESSES HAVE YOU EXPERIENCED?

PLEASE CHECK ANY DISEASES THAT YOU OR YOUR FAMILY HAVE SUFFERED

| | | | |
|-----------------------------|--------------------|---------------------|-----------|
| Alcohol/Drug Problems | Allergies | Alzheimers Disease | Anemia |
| Arthritis/Gout | Asthma | Bleeding Problems | Cancer |
| Convulsions/Epilepsy | Diabetes | Eczema | Emphysema |
| Heart Trouble | Hepatitis | High Blood Pressure | |
| Kidney or Bladder Problems | Menstrual Problems | Mental Illness | Migraines |
| Rheumatic Fever | Pneumonia | Polio | Stroke |
| Stomach /Intestinal Disease | Thyroid Problems | Tuberculosis | Ulcers |
| Venereal Disease | Weight Problems | | |

Office Info: