

# Homeopathic Intake Form (Constitutional Treatment Only)

*Important Notice: The information on this form is completely confidential and will be used only to determine appropriate Homeopathic treatment. Before filling it out, please contact us by phone at 888-558-1872.*

Today's Date \_\_\_\_\_

Full Name: Mrs., Ms, Mr. \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Birthtime (if known): \_\_\_:\_\_\_ Birthplace: \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Occupation(s): \_\_\_\_\_ Total hours per week: \_\_\_\_\_

Other Activities:  
\_\_\_\_\_

Overall level of satisfaction with life style (1 = lowest, 10 = highest): \_\_\_\_\_

Area(s) of life that bring greatest satisfaction: \_\_\_\_\_

Area(s) of life that bring the least satisfaction: \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Partner \_\_\_

Living situation: Alone \_\_\_ Spouse \_\_\_ Lover \_\_\_ Parents \_\_\_ Friends \_\_\_

Personality type? Keirseay Temperament or Myers-Briggs: \_\_\_\_\_

Enneagram: \_\_\_\_\_

(If you do not know one or the other or either of these, we recommend both.)

Is there anything else you think we should know at this point?

## **Health Information**

Height\_\_\_ Weight \_\_\_ Activity: Very High \_\_ High \_\_ Medium \_\_ Low \_\_

Overall health: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Very Poor \_\_\_

In a few words, describe the condition(s) or symptom(s) that leads you to want Homeopathic treatment:

Seriousness: \_\_\_\_\_ About when did they start: \_\_\_\_\_

Can you think of anything particular that happened within six months or a year before these appeared. This should be something that affected you emotionally.

### **(On separate pages if necessary)**

Describe those life experiences that have most deeply affected you, either positively or negatively.

Write a brief autobiography through to the present. This should only be an outline of the most important events. Your family history comes later.

Describe your early family life in some detail, through your early twenties. Then give a give a family history. List all relatives including siblings through grandparents with their ages. List their current and past illness as well as you can remember. If any of them have passed away, please give their ages at the time and the reason for death.

## Health Information (cont.)

Childhood Diseases (please indicate dates and severity):

|                       |                      |
|-----------------------|----------------------|
| Asthma_____           | Chickenpox_____      |
| Measles_____          | Mumps_____           |
| Polio (location)_____ | Rheumatic Fever_____ |
| Rubella_____          | Scarlet Fever_____   |
| Whooping Cough_____   | Other(s)_____        |

Indicate Immunizations:

DPT\_\_\_ MMR\_\_\_ HIB\_\_\_ Polio\_\_\_ Smallpox\_\_\_ TB\_\_\_ Pneumovac\_\_\_

Flu shots? \_\_\_ Frequency? \_\_\_\_\_ When was the last one? \_\_\_\_\_

Describe any adverse reactions to any immune shots you have had:

As completely as possible, please give a medical history. This can be from memory if you do not have records, but please indicate that this is the case. We need dates, severity, treatment, and long term results of the condition and its treatment as clearly as you can. This history should include accidents and psychological incidents as well as physical illnesses. Indicate the dates and length and locations of any hospitalizations. Do not consider any information to be insignificant.

Please list all medications, herbs, stimulants and other modalities you are currently using. This includes Acupuncture, Chiropractic, Massage, Yoga, Reiki, Marshal Arts, etc.

Do you have any allergies? If so, to what and under what conditions.

For women only:

When did menstruation begin? \_\_\_\_\_ (age).

Describe your menstrual cycle.

Describe your history of pregnancies, number including complications and way in which pregnancy finished.

**Referral Information:**

How did you hear about us? \_\_\_\_\_

If you have had Homeopathic treatment before, please list the practitioners and how to contact them. Please indicate for each one the condition that was treated and the results. If you know what remedies you took, you may list those as well.

Please sign and date this Intake Form. Do not forget to sign and date the disclaimer as well. We must receive that before we can begin.

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_