HOMEOPATHY

your pathway to health

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CONFIDENTIAL PATIENT INFORMATION
senior/adult/adolescent form

Pre-consultation information

This information must be completed before your appointment.

Homeopathy is a natural system of medicine that stimulates the body to heal itself. It does this by going to the root cause of your symptoms. All imbalances in your body lead to your illness and your symptoms. Your individual feelings and symptoms are the tools I need to help lead me to find your individual homeopathic remedy. Homeopathy follows the natural law of similars, like cures like. Fill in the information on this intake form as completely as possible, so that we can work together to bring your body back to health, that is to say, return you to an overall balanced state. Feel free to contact me at any time for further information.

Linda

General Information

NAME:____

ADDRESS:____

____

POSTAL CODE:____

PHONE: (home / work/ cell):____________________________

E-MAIL: ____

DATE OF BIRTH: year:________month:_________day:_______

Referred by:____

Medical doctor's name, location & phone #:______________

Signature:________________________Date:______________________

Initial Appointment:

Injuries/surgeries:

____

____

____

Sexually Transmitted Diseases:

Type: ______________ Age: ______ Type: ______________ Age: ______

Any adverse effects from vaccination?

Type: ______________ Age: ______ Type: ______________ Age: ______

Patient Information

MAJOR MEDICAL COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

	SINCE	CAUSES

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

	SINCE	ANY ADVERSE EFFECTS ON YOU

WHAT TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

	SINCE	RESULTS

CIRCLE EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses, Abortion, AIDS/HIV, Alcoholism, Allergies, Anemia, Anxiety Disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold Sores, Colitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Frequent Colds, Gallstones, Genital Herpes, Goiter, Gonorrhea, Gout, Hay Fever, Heart Disease, Hepatitis, Influenza, Kidney Disease, Leukemia, Malaria, Measles, Miscarriage, Mononucleosis, Mood Disorder, Mumps, Parasites, Pleurisy, Pneumonia, Post-Partum Depression, Prostatitis, Rheumatic Fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-Affected Disorder, Sexual Abuse, Sexually Transmitted Disease, Skin Diseases, Strep Throat, Sinusitis, Stroke, Sun Stroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid Fever, Venereal Warts, Warts, Whooping Cough, Worms, Yellow Fever.

ANY OTHER MAJOR CONDITIONS: ____________________

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN? WHICH ONE (S)?

____

WHAT OPERATIONS HAVE YOU HAD?	WHEN	COMPLICATIONS

HAVE YOU LOST ANY WEIGHT LATELY? Yes / No HOW MANY POUNDS?_________ WEIGHT? _______

WHAT EXERCISE DO YOU DO AND HOW MUCH? ____________________

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO: ______ ALCOHOL:________ COFFEE: _____ "RECREATIONAL" DRUGS: _________________

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN (S)?

WHO	FOR WHAT CONDITIONS?	TREATMENT

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE? Yes / No HOMEOPATH: _________________
WHEN? ________________ REMEDIES? ____________________

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE (e.g. ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, ETC.)

ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

TYPICAL BREAKFAST / LUNCH / DINNER / SNACKS: (please give me a 3 day sample)

Day 1:____________________

Day 2: ____________________

Day 3:____________________

ANY SENSITIVITY TO MEDICATION?

LIST ALL SUPPLEMENTS THAT YOU TAKE:

Health History of Relatives

Alcoholism, Allergies, Arthritis, Anemia, Asthma, Cancer, Depression, Diabetes, Eczema, Epilepsy, Gonorrhea, Gout, Hay Fever, Heart Disease, High Blood Pressure, Mental Illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS: ____________________________

Your Family Health History: alive or deceased age major ailments

Mother____

Father____

Sisters____

Brothers____

Maternal grand-mother____

Maternal grand-father____

Maternal aunts____

Maternal uncles____

Paternal grand-mother____

Paternal grand-father____

Paternal aunts____

Paternal uncles____

Your children____

PLEASE MENTION ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CASE:

____

____

Thank you for taking the time to complete this form.

All information contained herein will remain strictly confidential.

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Linda Fraser Waldmann is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Linda Fraser Waldmann, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule.

Signature:_______________________________Date:____________________________

Witness:_______________________________________