Ana Komazec B.Sc., DHMHS, HD **Classical Homeopathic Practitioner**
www.kwhomeopathy.com www.vibrant-living.ca
519.772. 0292

HOMEOPATHIC CONSULTATION

ADULT INTAKE FORM

Please read the following before filling this form:

Thank You for taking time to start your path to health and wellness. In order to thoroughly select the best indicated homeopathic remedy for you, the intake and consultation requires your detailed and honest co-operation. In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. This is to ensure that a best possible homeopathic remedy is selected based on the information you provide. During consultation many questions will be asked that have definite homeopathic case taking meaning and significance. Questions pertaining to details of your health concerns, your mental state and emotional nature, your reactions to various factors, past family and personal history. It is necessary for us to know about your past ailments, diseases, and treatments. Information provided and obtained from consultation allow us to treat you on a whole combining on totality the mental, emotional, physical and spiritual levels that encompass who you are as an individual.

How to describe your complaints during homeopathic consultation:

Physical Location: Please give exact location of pain, sensation or eruptions and if the pain or sensation spreads anywhere else.

Sensation: Describe and express fully the type of pain and sensation you experience. For instance, the pain could be burning, sharp, jumping, piercing, pressing, etc and sensation could be something like worms crawling, heart grasped by hand, etc.

Better or Worse: There are many factors that influence you physically, mentally and emotionally. Some may intensify your complaints and other factors may alleviate. It is vital to know how the factors and triggers affect you, For example, headache that is worse in sun. Some factors include, hot, cold rainy, cloudy weather, change of seasons, dust, smoke, lying, up or downstairs, running, walking, cold bathing, covering, thunder storm, sexual intercourse, sleep, pressure, touch, noise, music, etc.....

Concomitants: Are there any other conditions that co exist with your primary complaints?

Mental and Emotional: It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is necessary for us to understand your emotional and intellectual nature so that we can treat you as a whole. Important are your reactions to stressors in life, to situations, and your personality traits, as well as dreams and spiritual/religious aspect.

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ADULT HOMEOPATHIC INTAKE FORM

Date/Year: ___________

First Name: ____________________________

Last Name: ____________________________

Age: _________ Gender: Male / Female Currently Pregnant? Yes / No

Weight: ___________________ Height: ________________

Address: ____

City: ________________________ Postal Code: _______________

Home Phone #: ________________ Cellular #: ____________________

Email: ________________________

Would you like to be on our e-mailing list for upcoming lectures and new information? Yes/ No

Occupation: ____________________________

Marital Status: Single/Married/Divorced/Widowed # Children/ages: __________

How did you hear about us? ____

Family Physician Name: _______________________________ Phone: _______________

Emergency Contact Name: ____

Emergency Contact Relation: ____

Emergency Contact Phone: _____________________

Please list Major Complaints in order of importance:

Complaint	Since When	Causes/Origin

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Please circle all conditions that you have had in the past or that you currently have:

Abscesses	Acne	Abortion	Alcoholism	Anemia	Anxiety
Allergies	Arthritis	Cancer	Chicken Pox	Chronic Fatigue	Crohn's Disease
Cold Sores	Colitis	Depression	Diabetes	Diverticulitis	Drug Abuse
Eczema	Emphysema	Endometriosis	Epilepsy	Frequent Colds	Fibromyalgia
Gall stones	Goitre	Gonorrhoea	Gout	Headaches	Heart Disease
Heart Stroke	Hepatitis	Hay Fever	HIV	High Blood Pressure	Herpes Genitalia
Hyperthyroidism	Hypothyroidism	Influenza	Irritable Bowel	Intestinal Worms	Indigestion
Jaundice	Kidney Disease	Leukemia	Liver Disease	Low Blood Pressure	Lyme Disease
Malaria	Measles	Mononucleosis	Migraine	Miscarriage	Multiple Sclerosis
Mumps	Nosebleeds	Ovarian Cysts	Infertility	Premenstrual syndrome	Pneumonia
Parasites	Peritonitis	Prostatitis	Psoriasis	Pelvic Inflamatory Disease	Polyps
Rheumatic Fever	Sexual Abuse	Sinusitis	Sun stroke	Strep Throat	Skin Disease
Syphilis	Tonsilitis	Tuberculosis	Typhoid Fever	Thyroid Issues	Urinary Tract Infectio
Urticaria	Ulcers	Venereal Warts	Warts	Whooping Cough	Yellow Fever
Yeast Infections					

Other physical, mental, emotional conditions not listed above:

____

____

____

List most traumatic moments in life, major stressors and shocking events and how it has affected you:

____

____

____

List Operations and Injuries in the past or present:

Operations/Injuries	When?	Complications

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Please list all medications that you currently take / have taken in the last year:

____

____

____

Please list all nutritional supplements, herbs, homeopathic remedies currently taking:

____

____

____

Please list any complementary medical therapies and treatments that you are currently undergoing or have undergone in the past year? For instance, chiropractic, acupuncture, herbs, etc...

____

____

List any allergies or sensitivities to medications or any other substances:

____

____

Known allergies are worse when, please check:

___spring ___summer ___autumn ___winter ___outdoor ___dampness ___indoor ___food

Please check if currently taking any of the following substances:

Alcohol How much? __________ Cigarettes How much? ______________

Chewing tobacco How much? __________ Coffee/Tea How much? ______________

Recreational drugs Type: ______________ Pain Killers Amount /Dose? ___________

Sleeping Pills How frequent? _________ Laxatives How Frequent? ___________

Have you notice a loss in weight recently? Yes/ No How much loss? ________________

Please circle all vaccinations that you have had:

Tetanus/Diphtheria/Polio ("DPT") Hepatitis Measles/Mumps/Rubella ("MMR")

Chicken Pox Whooping Cough Influenza Other: ________________________________

Any adverse reactions or particular trouble to vaccinations, if so, please list symptoms?

____

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Please circle all that apply to your family medical history:

Alcoholism	Cancer	Depression	Heart Disease	Gonorrhoea
Malaria	Alzheimer's Disease	Diabetes	Stroke Anxiety	Dementia
Migraines	Syphilis	Rheumatism	Hypertension	Epilepsy
Paralysis	Liver Disease	Kidney Disease Asthma		Insanity

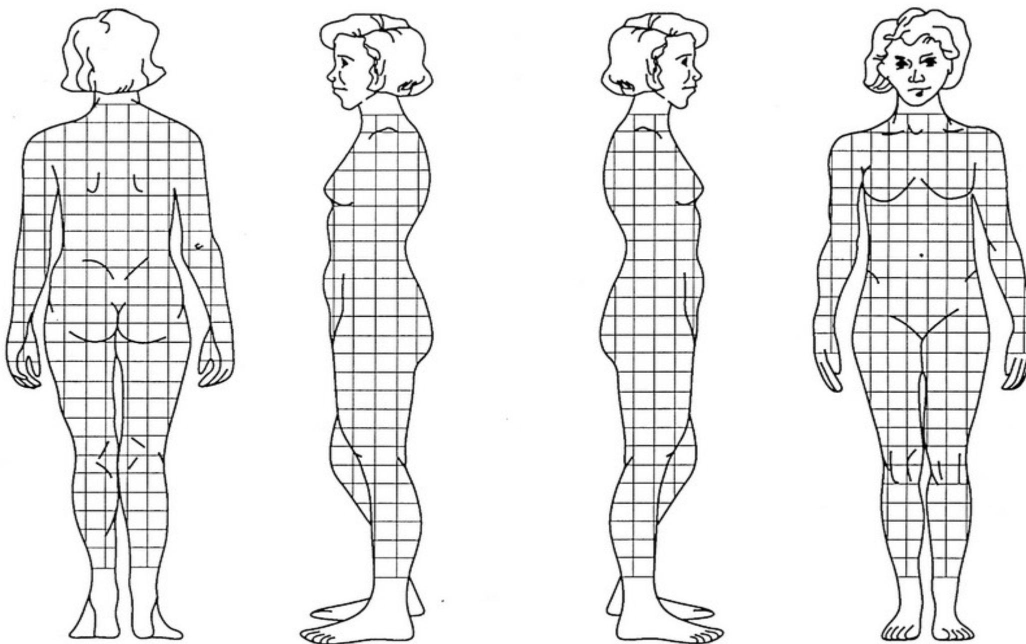
Other: ____

If you are currently seeing any other natural health practitioners pertaining to your health complaints, please list below the name and contact:

Name: ______________________________ Contact #: ____________________

Name: ______________________________ Contact #: ____________________

Please take time to indicate the areas of your concerns of pain and discomfort by marking X:



Client Intake Form Acknowledgment:

I, ______________________________, on this date and year ____________________, acknowledge that all above information provided by me has been done to my best ability and honesty.

Signature: ______________________________ Date/Year: ______________

Print Name: ____

Thank You for taking time to complete the intake. Thank You for starting a pathway to health.
All information provided remains confidential.