Nature's Mark Homeopathy

Lori Reeves, HOM, DCHM

613-757-1268

Email: lori@naturesmark.ca

CONFIDENTIAL ACUTE CONSULTATION FORM

Name: ___________________________________Date of Birth: D_____ M_____ Y_____ Age____

Address: ____

Telephone: Home:______________ Work: _______________Other: ______________________

Email Address: ____

Referred By: _____________________ Present M.D. and Phone # ________________________

Emergency Contact Name: ________________________ Phone: _________________________

Chief Concern

What is the nature of your acute condition? Since When?

____

____

____

What medications and/or supplements are you taking for this problem?

____

____

Are you receiving any other treatment for this problem? If so, what and by whom?

____

____

What do you feel was the cause of this problem?

____

____

Sensation/Feeling:

Describe how this acute condition feels? ____

____

Are there any other sensations that occur with your acute condition?

____

What is the intensity of your condition? (Please circle)

Very Mild ……1…..2…..3…..4…..5…..6……7……8……9……10 extremely intense

How frequently do you experience the effects of this problem? (Please circle one or more)

Constantly Hourly Daily Nightly Other: ____________________________________

TEMPERATURE		**ENVIRONMENT**		**MOTIONS**		**BODY FUNCTIONS**	
HEAT		Damp		Commencing motion		Eating	
Heat in general		Humid		Continued motion		Drinking	
Heat of the sun		Windy		Exertion		Urinating	
Warmth of a bed		Weather Changes		Rising Up		Defecating	
Warm rooms		Overcast/Stormy		Resting		Sleeping	
Application of heat		At an Altitude		Stretching		Coughing	
Warm water		Indoors		Lifting		Yawning	
Cold		Outdoors		**POSITION**		Sneezing	
Cold in general		By the sea		Lying		Sexual Activiy	
Cold air/draft		Other		Standing		Other	
Cold water		**SENSORY**		Sitting		**PSYCHOLOGICAL**	
Cold application		Touch		Stooping		Excitement	
		Pressure		Doubled Up		Effects of Anger	
		Noise		Right side		Fear of Shock	
		Music		Left side		Stress	
		Light		Stiff		Worry	
		Darkness		Limp		Thinking about it	
		Odours				While busy	

Do you experience any other symptoms at the same time as this pain? (Ex. diarrhea, perspiration, nausea)

____

How do you feel mentally/emotionally with this problem? ____________________________________

____

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 Lori Reeves is a Homeopath 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 Lori Reeves, 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. I acknowledge that all personal information will be kept confidential.

Patient Signature: ____ Date: ____________

Patient-Guardian Name (If signed on behalf of a patient who is under 19 years of age)

Guardian Name: ____

Guardian Signature: ____ Date: ____________

Please note that all the information you share is kept in the strictest confidence according to the laws of Homeopath-Patient confidentiality.