Nature's Mark Homeopathy

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CONFIDENTIAL ADULT PATIENT CONSULTATION FORM

Note to Patient: Determining the proper remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment.

In order to develop an accurate picture of your situation, and to make the most effective use of our time, I request that you complete the following information form as accurately as possible.

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

Name: _____ Surname: _____

Date of Birth: D_____M_____Y_____

Address: Street_____ # _____ Apt _____ City _____ Postal _____

Telephone: Home: _____Work: _____Other_____

Email Address: _____

Family Doctor

Full Name: _____

Practice Phone: _____

Patient Referred by: _____

CURRENT PERSONAL HEALTH SITUATION

Are you currently under the care of a physician or medical specialist? YES / NO (Circle One)

If you are being treated by a Medical Specialist please indicate what type?

Medical Conditions (Please list your major health issues in order of importance to you)

Medical Condition	How Long?	Cause?

What Prescription Medications Are You Currently Taking?

Prescription Medication Name	How Long?	Adverse Affects

What Treatments Or Therapies Are You Currently Following?

Treatment/Therapy	How Long?	Adverse Affects

Any Allergies? **YES / NO (Circle One) If "YES", please write your allergies down**

Allergy	Since	Severity

Are there any of the preceding conditions which after you had or contracted it/them you have never been well since?

What Operations have you had?

_____

_____

_____

Any Complications after the operation(s)?

_____

_____

_____

What Major Injuries Have You Had Through The Course Of Your Life?

_____

_____

Have you lost or gained any weight lately? Lost / Gained (Circle One)

How many pounds or kilograms? _____LBS / KGS (Circle One)

What type of exercise do you do?

_____

_____

How often? _____

Do you smoke? _____ Cigarettes / Cigars / Pipe Tobacco (If Yes Circle One)

How many do you smoke per day? _____

Do you drink Alcohol? YES / NO (Circle One)

If YES, please specify what type(s) of Alcohol _____

How much alcohol do you consume? _____Per Day/ Per Week

Do you use recreational drugs? YES / NO (Circle One)

What type of recreational drugs do you take?

_____

How often do you take them and how much do you take?

_____Per Day/ Per Week

Have you suffered any serious shock, grief, disappointment, fright, etc?

YES / NO

If YES please specify what it was and when:

_____

_____

_____

PERSONAL MEDICAL HISTORY

Immunizations	**(Circle One)**	**Any Adverse Reactions?**
Measles	YES / NO	YES / NO
Mumps	YES / NO	YES / NO
Rubella/German Measles	YES / NO	YES / NO
Chicken Pox	YES / NO	YES / NO
Whooping Cough	YES / NO	YES / NO
Meningitis	YES / NO	YES / NO
Hep B	YES / NO	YES / NO
Tetanus	YES / NO	YES / NO
Haemophilias	YES / NO	YES / NO
Pneumococcal	YES / NO	YES / NO
DPPT	YES / NO	YES / NO
HPV	YES / NO	YES / NO
Herpes Zoster/Shingles	YES / NO	YES / NO

Please Circle If You Have Suffered From Any Of The Following Conditions In The Past.

Abscesses	Alcoholism	Allergies	Anemia	Arthritis	Asthma	Cancer
Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Eczema	Emphysema
Epilepsy	Frequent Colds	Gallstones	Gonorrhea	Gout	Hay Fever	Heart Disease
Hepatitis	Herpes	Influenza	Kidney Disease	Leukemia	Lyme's Disease	
Malaria	Measles	Miscarriage	Mononucleosis	Mumps	Multiple Sclerosis	

Parasites Pleurisy Pneumonia Prostatitis Psoriasis Rheumatic Fever Rubella

Scarlet Fever Sexual Abuse Sinusitis Strep Throat Stroke Sun Stroke Thyroid Issues

Tonsillitis Tuberculosis Typhoid Fever Venereal Warts Warts Whooping Cough

Worms Yellow Fever

Any Other Major Conditions Not Listed Above (Please specify)

_____

_____

FAMILY MEMBER MEDICAL HISTORY

Member	**Age if Alive**	**Age at Death**	**Ailments**
Mother	_____	_____	_____
Father	_____	_____	_____
Sister 1	_____	_____	_____
Sister 2	_____	_____	_____
Brother 1	_____	_____	_____
Brother 2	_____	_____	_____
Maternal Grandmother	____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunts/Uncles	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunts/Uncles	_____	_____	_____

Have you ever been treated with homeopathy before? YES / NO (Circle One)

If "YES" what were you treating and what was the outcome?

_____

_____

_____

Is there any other information that I would need to know?

_____

_____

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: _____