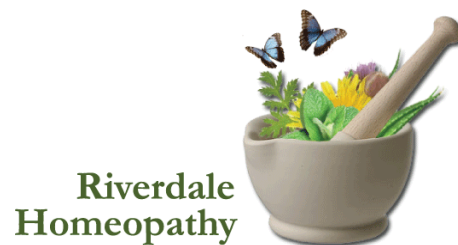


# Riverdale Homeopathic Clinic

## Intake Form



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

\_\_\_\_\_

Telephone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our newsletter? Yes \_\_\_ No \_\_\_

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

### *Major Complaints*

Complaint	Since	Cause(s)

### *Current Medications/Supplements*

Medication/Supplement	Since	Reasons

### *Other Treatments/Regimes Currently Following*

Treatment/Regime	Since	Cause(s)

Have you been treated with Homeopathy before? \_\_\_\_\_ If yes who was your practitioner?

Practitioner: \_\_\_\_\_ When: \_\_\_\_\_

***What homeopathic remedies have you taken?***

Remedy	When	Response

Are you currently under the care of a physician (s)? Yes    No

Physician: \_\_\_\_\_ Condition(s): \_\_\_\_\_

Other Practitioners?

Name: \_\_\_\_\_ Phone number \_\_\_\_\_

Name: \_\_\_\_\_ Phone number \_\_\_\_\_

***Please Indicate Which of the Following Conditions You Have / Had***

Abscesses		Cold Sores		Hay fever		Malaria		Rubella		Tuberculosis	
Alcoholism		Depression		Heart disease		Mononucleosis		Scarlet fever		Typhoid fever	
Allergies		Diabetes		Hepatitis		Mumps		Sexual abuse		Venereal warts	
Asthma		Epilepsy		Herpes		Measles		Skin disease		Warts	
Arthritis		Gallstones		Influenza		Parasites		Sinusitis		Whooping cough	
Cancer		Gonorrhea		Kidney disease		Pneumonia		Syphilis			

Do you have any preceding conditions which are worse than usual or that you never fully recovered from?

Which ones?

---

---

---

---

Any events after which you have never felt well?

---

---

---

***What surgeries have you had?***

Surgery	When	Complications?

***What injuries have you had?***

<b>Injury</b>	<b>When</b>	<b>Long term effects</b>

How often do you consume the following substances:

Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Drugs (non-prescription) \_\_\_\_\_

Have you lost/gained any weight lately? How much? \_\_\_\_\_

Do you exercise? How often and what do you do? \_\_\_\_\_

\_\_\_\_\_

Age of first menstruation: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Have you ever taken birth control? \_\_\_\_\_

Do you or have you ever had amalgam fillings (silver fillings): \_\_\_\_\_

***Please Indicate (☐) Which of the Following Conditions have affected your relatives:***

Alcoholism	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>

<b>Relative</b>	<b>Age (if alive)</b>	<b>Age at Death</b>	<b>Illnesses</b> (ex. Diabetes, cancer, mental illness)
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunt/Uncle			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt/Uncle			