CONFIDENTIAL

PERSONAL INFORMATION

Date: _______________

Last name: ___________________________________ First name: ________________________

Address: _____________________________________ City: ____________________________

Postal code: _______________

Phone # Home: __________________ Work: __________________ Cell.: _______________

E-mail address: ____

Date of birth: ______________________ Age: _____

Occupation: ____

Have you ever consulted a homeopath or naturopath? _____ When? ____________

What was his/her name? ____

Are you under the care of any other therapist right now? ____

Please describe: _______________________________________

How did you hear about me? ____

MEDICAL QUESTIONNAIRE

Please list your main complaints/symptoms/conditions and the date of onset for each one:

1. ____

2. ____

3. ____

4. ____

5. ____

Please list all medications that you take:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Please list all supplements/vitamins/other remedies that you take:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Have you had any significant accidents/traumas? ____________ When? _______________

Please describe ____

____

Have you had any surgeries? ______ When? ______________

Please describe: ____

____

Have you had any recent vaccinations? ________ When? _____________________

Which one(s)? ____

Have you ever had an adverse reaction to vaccines? ______

Please describe: ____

Do any of these conditions, past or present, apply to you?

Abscesses
Acne
Alcoholism
Anemia
Allergies
Arthritis
Asthma
Athletes foot
Back pain
Cancer
Candida
Cankers
Cold sores
Constipation
Convulsions
Cystitis
Depression

Diabetes
Diarrhea
Emphysema
Endometriosis
Eczema
Epilepsy
Fibromyalgia
Gallstones
Goiter
Gonorrhea
Gout
Genital warts
Hay fever
Headaches
Heartburn
Heart disease
HIV/Aids

Herpes
Hepatitis
High blood pressure
Hypo/Hyperthyroid
Joint pain
Low blood pressure
Kidney disease
Leukemia
Mononucleosis
Mumps
Parasites
Pleurisy
Pneumonia
Prostatitis
PMS
Rheumatic fever
Rubella

Scarlet fever
Sexual abuse
Sinusitis
Stroke
Strep throat
Syphilis
Tonsillitis
Tuberculosis
Varicose veins
Warts
Whooping cough
Worms
Yeast infections

Family Health History

	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Please circle any of the conditions that have affected your family:

Alcoholism   Allergies   Arthritis   Asthma   Cancer   Depression   Diabetes   Epilepsy

Gonorrhea   Gout   Heart disease   Mental illness   Pneumonia   Skin disease

Syphilis   Tuberculosis

LIFESTYLE QUESTIONNAIRE

How often do you drink alcoholic beverages? _______________

How many cups of coffee do you drink per day? _____________

Do you smoke? ____ How much? _____________________

Do you use recreational drugs? ____ How often? __________

Do you exercise? ____ How many times per week? _____ What type? ________________

____

How much time do you take for relaxation and in what form(s)? ___________________________

____

What are your main interests, hobbies and pastimes? ____________________________________

____

Do you have any food sensitivities/allergies? _____ Please describe: _______________________

____

FOR WOMEN ONLY

Are you pregnant? ______ Due date: ____________________

How old were you when you experienced your first period? ________

How would you describe your periods? ____

What is the duration of your cycle? (From the first day of your period to the first day of the next period)

____

Do you suffer from PMS? ______

Are you pre-menopausal? ______ Post-menopausal? ______

How many pregnancies have you had? _____ How many children do you have? _____

Have you had any miscarriages? ______ How many? ______