

Adult New Patient

Name _____ Birthdate _____

Address _____ City _____ Zip _____

PHONE - Home _____ Work _____ Cell _____

Fax _____ e-mail address _____ Marital Status _____

Occupation _____ Who referred you ? _____

Prior Homeopathic treatment ? ___ By Whom _____ Date Last Seen _____

IN THE EVENT OF EMERGENCY PLEASE NOTIFY:

NAME _____ PHONE _____

MEMBERS OF YOUR HOUSEHOLD

NAME	AGE	RELATIONSHIP
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (please list all known or suspected drug sensitivities and environmental allergies)

MEDICATIONS, VITAMINS and SUPPLEMENTS (include non-prescription and herbs)

NAME	DOSAGE	FREQUENCY
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HEALTH HABITS

How many times each week do you exercise for 40 minutes or more ? _____

How do you exercise ? _____

Do you smoke cigarettes ? ___ If so, how many each day ? _____ At what age did you start ? _____

Do you drink alcohol ? ___ How much weekly ? _____

Are you concerned about your use of alcohol ? ___

Do you use other recreational drugs ? _____ Are you concerned about your use of those drugs ? _____

Do you drink coffee ? _____ How much ? _____ Do you eat a well balanced breakfast ? _____

Do you wear seat belts every time you are in an automobile ? _____ Are you a careful driver ? _____

Do you set aside enough time for adequate relaxation ? _____ How do you relax ? _____

ARE YOU EXPOSED TO ANY TOXIC SUBSTANCES ? (Please provide details regarding those exposures that concern you)

WHAT HEALTH PROBLEMS ARE YOU PARTICULARLY CONCERNED ABOUT ?

WHAT RECENT LOSSES OR UNUSUAL STRESSES HAVE YOU EXPERIENCED ?

PLEASE CIRCLE ANY DISEASES THAT YOU OR YOUR FAMILY HAVE SUFFERED

Alcohol/Drug Problems Allergies Alzheimer's Disease Anemia Arthritis/Gout

Asthma Bleeding Problems Cancer Convulsions/Epilepsy Diabetes

Eczema Emphysema Heart Trouble Hepatitis High Blood Pressure

Kidney or Bladder Problems Menstrual Problems Mental Illness Migraines

Pneumonia Polio Rheumatic Fever Stomach /Intestinal Disease Stroke

Thyroid Problems Tuberculosis Ulcers Weight Problems