

Christine Dezeng Homeopathy

PATIENT INTAKE FORMS

Patient Information

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU

SINCE

CAUSES

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT

MEDICATIONS ARE YOU CURRENTLY TAKING?

SINCE

ANY ADVERSE EFFECTS ON YOU

_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT

TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

SINCE

RESULTS

_____	_____	_____
_____	_____	_____

CIRCLE

EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses, AIDS/HIV, Alcoholism, Anemia, Anxiety disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold sores, Colitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Gallstones, Goitre, Gonorrhea, Gout, Hay fever, Heart disease, Hepatitis, Herpes genitalia, Influenza, Kidney disease, Leukemia, Malaria, Measles, Miscarriage, Mononucleosis, Mood disorder, Mumps, Parasites, Pleurisy, Pneumonia, Post-partum depression, Prostatitis, Rheumatic fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-affected disorder, Sexual abuse, Skin disease, Strep throat, Sinusitis, Stroke, Syphilis, Tonsilitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping cough, Worms, Yellow fever.

ANY OTHER MAJOR CONDITIONS: _____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN? WHICH ONE (S)?

_____	_____	_____
_____	_____	_____

WHAT OPERATIONS HAVE YOU HAD?

WHEN

COMPLICATIONS

HAVE YOU LOST ANY WEIGHT LATELY? HOW MANY POUNDS? _____

WHAT EXERCISE DO YOU DO AND HOW MUCH? _____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO: _____ ALCOHOL: _____

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COFFEE: _____ “RECREATIONAL” DRUGS: _____

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN (S)?

WHO FOR WHAT CONDITIONS? TREATMENT

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

HOMEOPATH WHEN?

FOR WHAT CONDITIONS?

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE (e.g. ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, ETC.)

SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.? ANY

Health History of Relatives

Alcoholism, Allergies, Arthritis, Asthma, Cancer, Depression, Diabetes, Epilepsy, Gonorrhea, Gout, Hay fever, Heart disease, Mental Illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS: _____

AGE IF ALIVE	AGE AT & CAUSE OF DEATH	AILMENTS
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MOTHER: _____

FATHER: _____

BROTHERS: _____

SISTERS: _____

CHILDREN: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

MATERNAL AUNTS/UNCLES: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

PATERNAL AUNTS/UNCLES: _____

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IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CASE THAT YOU WOULD LIKE TO MENTION_____

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.