HOMEOPATHIC ENQUIRY FORM - CONFIDENTIAL

Please provide the following information about yourself & return before your appointment.

NAME: . . . . . DATE OF BIRTH: . . . . . .

POSTAL ADDRESS:. . . . .

. . . .

EMAIL ADDRESS:. . . . . .

TELEPHONE: . . . . . .MOBILE :. . . . . .

MARITAL STATUS: . . . . . NO & AGE OF CHILDREN: . . . . . .

OCCUPATION: . . . . . .

PREVIOUS OCCUPATIONS:. . . . . .

NAME & ADDRESS OF YOUR G.P.:. . . . . ..

. . . . . .

BRIEF DETAILS ABOUT YOUR MAIN REASON FOR SEEKING TREATMENT:

DETAILS OF ANY CURRENT MEDICINES OR TREATMENT:

DETAILS OF ANY MEDICINES OR TREATMENT YOU HAVE HAD IN THE PAST:

DETAILS OF ANY CHILDHOOD ILLNESSES / OPERATIONS / ACCIDENTS / SIGNIFICANT LIFE EVENTS (Please give dates/approx age):

Apart from your main reason for seeking treatment, please indicate whether you have ever had any problems with any of the following, using ‘R’ if recent (within the last year) or ‘P’ if in the past:

Memory	[ ]	Varicose veins	[ ]
Concentration	[ ]	Skin conditions	[ ]
Dizzyness, vertigo	[ ]	Boils	[ ]
Fainting	[ ]	Warts	[ ]
Depression	[ ]	Cramps	[ ]
Speech	[ ]	Numbness / tingling	[ ]
Headaches	[ ]	Pins & needles	[ ]
Ears & hearing	[ ]	Glands	[ ]
Eyes & vision	[ ]	Itching	[ ]
Nose & smell	[ ]	Nails	[ ]
Mouth & taste	[ ]	Hernias	[ ]
Face	[ ]	Twitches / trembling	[ ]
Teeth	[ ]	Ulcers	[ ]
Throat	[ ]	Menstrual periods	[ ]
Respiration	[ ]	Menopause	[ ]
Coughs	[ ]	Pregnancy	[ ]
Heart	[ ]	Sweats	[ ]
Digestion	[ ]	Water retention	[ ]
Bowels	[ ]	Alcohol dependency	[ ]
Bladder	[ ]	Drug dependency	[ ]
Genitals	[ ]	Venereal / STDs	[ ]
Joints	[ ]	Allergies	[ ]

FAMILY MEDICAL HISTORY Please give details of medical history (if known) of grand-parents, parents and siblings. If deceased, state at what age and cause of death if known.

ANY OTHER INFORMATION YOU THINK MAY BE RELEVANT