Restore True Health Homeopathy

CLIENT INFORMATION

Date:

Full Name:

Birth Date:

Email:

Phone #:

Address:

Profession:

Height: **Weight:**

Relationship Status: **Married** **Single** **Divorced** **Widowed**

Check Box indicating vaccine received and write year received, if possible:

	MMR (Measles, Mumps, Rubella)		**Polio**
	Tdap (tetanus, diptheria, pertussis)		**Influenza (list years taken)**
	HPV (Human papillomavirus)		**Chickenpox (Varicella)**
	Meningococcal		**Covid (please provide # doses & brand taken)**
	Pneumococcal		**Small pox**
	Dengue		**Shingles**
	Hepatitis A		**Rabies**
	Hepatitis B		**Rotavirus**
			Other:

Family medical history (parents & grandparents on both sides):

Personal medical history & any past surgeries:

Current OTC medications, doctor prescriptions and supplements taking:

When was your last high fever (above 101.3)? What were the symptoms at the time?

How often do you experience a common cold? Does the cold resolve on its own or does it go into secondary infections?

Do you suffer from any skin issues or had skin issues in the past?

Have you even suffered from a concussion? If so, how long ago?

How would you describe your personality?

What is the main reason you are seeking homeopathic care?

Have you ever used homeopathic remedies in the past? If so, which remedy and for what symptom: