Joanne Breeze
Homeopath (HOM) Registration Number 15586
Contact Information:

Name:	**Address:**
D.O.B	**Referred by:**
Home phone:	**Email:**
Cell phone:	**Emergency Contact:**
Marital status:	**Number of children:**
Occupation:	**Employer:**

Major complaints in order of importance to you:

Complaint?	**Since?**	**Cause?**

What medications/supplements are you currently taking?

Medication?	**Since?**	**Adverse effects?**

What other treatments or therapy are you currently following?

Treatment or therapy?	**Since?**	**Results?**

Which of the following conditions have you had: Past and present.

Abscesses Acne Alcoholism Addiction Asthma Anemia Arthritis Anxiety Alopecia ADHD/ADD Autism Aspergers Cancer Chicken pox Cold Sores Bronchitis Blood disorders Boils COPD Croup Crohn's Colitis Celiac disease Cradle cap Diverticulitis Depression Diabetes Diaper rash Epilepsy Eczema Gallstones Goitre Gastritis Gonorrhea Gout Heartburn/Acid reflux Hay Fever High Blood Pressure Heart Disease Hepatitis Herpes Influenza IBS Kidney Disease Lupus Leaky Gut Leukemia Malaria MS Measles Miscarriage Mono Mumps Miners OCD PCOS PID Peritonitis Pleurisy Pneumonia Prostatitis Parasites Physical Abuse Psoriasis Rubella Rheumatic Fever Raynaud's phenomenon Scarlet Fever Sexual Abuse Strep Throat Shingles Sinusitis Sunstroke Syphilis Sleepwalking Sleep Apnea TMJ Tonsillitis Tuberculosis Typhoid Fever Venereal disease Warts Worms Whooping Cough
Any other conditions not listed?_____

Are any conditions in which you have contracted and not felt completely well since? Do you feel like you have not completely recovered from the condition?

_____

Please list seasonal and food allergies/sensitivities you many have:

Irritant?	Since when?	Symptoms?

What surgeries or procedures have you had?

Procedure?	When?	Complications?

What are the 3 major emotional traumas or physical injuries have you had in your life?

Injury:	When:	Long term effects:

Vaccinations:

Is your vaccination schedule up to date as per Health Canada guideline? Y/N
Have you suffered any adverse reaction to a vaccination? Y/N
If so which vaccination? _____
What were the adverse effects? _____

Lifestyle and activities:

Are you physically active? Y/N
If so, how often?_____
What is your preferred activity? _____
Cardio, Weight training, Yoga, Zumba, Dancing, Rock climbing.... Etc.

How often are you consuming the following substances?

Alcohol	
Tobacco products	
Recreational drugs	
Coffee	
Other	

Please list as much information as you can about you family health history.

Relative	Age if alive	Age at death	Aliments/Cause of death.
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please list any additional family members information:_____

Are you currently under a Physician's care?

Physician?	For what condition?	Treatments?

Have you been treated with Homeopathy before?

Practitioner?	For what condition?	When?	Results?

Please list your support system.
The path to wellness is not a straight line. Having someone you can trust and support you along your journey is beneficial to your overall well being.

Name:	Phone number:	Relationship?

Consent to treatment:

I _____ understand that Joanne Breeze is a Homeopath and not a licenced medical doctor. I acknowledge that it is my responsibility to seek medical diagnosis for my present and future conditions. In consulting with Joanne Breeze, I am exercising my right to choose an alternative method of treatment. As Homeopathy is not covered by the existing government medical insurance plan (OHIP), I agree to pay all fees present in the current rate schedule. Your personal medical benefits plan may cover Homeopathy, please submit the invoices provided. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive emails from Joanne Breeze and/or Let it Heal Pain and Detox Clinic which will provide me with relevant health information including newsletters, upcoming events relating to Homeopathy, Bowen therapy and other natural health modalities. I understand that I can unsubscribe to these emails at any time.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____