
## Rose Blanche Wellness Homeopathic Consultation Form

Name: _____ Date of Birth: D_____ M_____ Y_____

Address: _____

Street City Postal code

Telephone: Home: _____ Work: _____ Cell:_____

E-mail Address: _____Emergency Contact: _____

Referred By: _____ Present M.D. and Phone #:_____

**Major complaints in order of importance for you:**

| Complaint | Since | Causes |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Which medications are you currently taking?**

| Medication | Since | Adverse Effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**What other treatments or regimens are you currently following?**

| Treatment or Regimen | Since | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Which of The Following Conditions Have You Had?**

| | | | | | | |
|---|---|---|---|---|---|---|
| Abscesses | Alcoholism | Allergies | Amnesia | Anemia | Arthritis | Asthma |
| Cancer | Chicken Pox | Cold Sore | Colitis | Depression | Diabetes | Emphysema |
| Epilepsy | Gallstones | Goiter | Gonorrhea | Gout | Hay Fever | Heart Disease |
| Hepatitis | Herpes | Influenza | Kidney Disease | Leukemia | Malaria | Measles |
| Miscarriage | Mononucleosis | Mumps | Parasites | Pelvic Inflammatory Disease | | PCOS |
| Pleurisy | Pneumonia | Prostatitis | Rheumatic Fever | Rubella | Scarlet Fever | |
| Sexual Abuse | Skin Disease | Strep Throat | Sinusitis | Stroke | Sun Stroke | Thyroid Issue |
| Tonsillitis | Tuberculosis | Warts | Whooping Cough | Worms | Yellow Fever | |

**Any other major conditions?**

_____

**Are there any of the preceding conditions after which you have not been totally well again?**

**Which Ones?**

_____

**(Women)Age of first Menses:** _____ **(Women)Number of Pregnancies:** _____

**Are You Currently Under the Care of a Physician(s)?**

Physician _____ For which condition? _____ Treatments: _____

ROSE BLANCHE WELLNESS

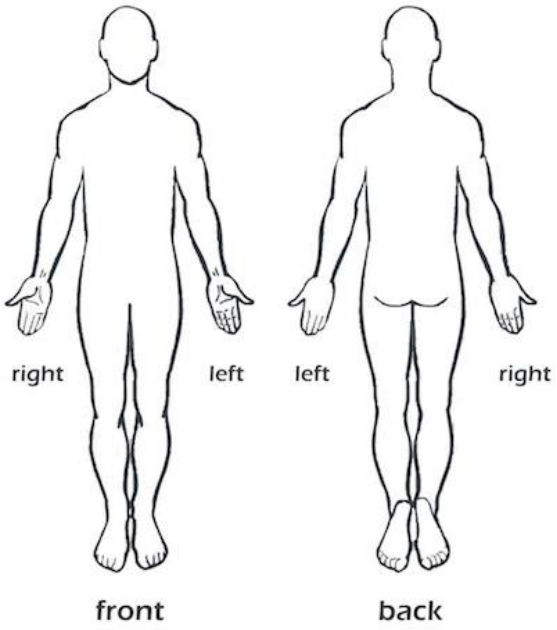
Located at 2227 Bel Pre Rd. #102
Silver Spring, MD 20906
Phone (240) 945- 6693
Website: roseblanchewellness.com

**What major operations have you had?**

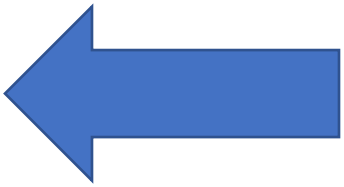
| Operation | When | Complications |
|---|---|---|
| | | |
| | | |
| | | |

**What major injuries have you had?**

| Injury | When | Complications |
|---|---|---|
| | | |
| | | |
| | | |




**Please CIRCLE on the diagram any areas of concern**



**How much of the following substances are you using?**

**Tobacco_____Alcohol_____Coffee_____ Recreational Drugs_____**

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**Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:**

Alcoholism Allergies Arthritis Asthma

Cancer Depression Diabetes Epilepsy

Gonorrhea Gout Heart Disease Insanity

Paralysis Pneumonia Skin Disease Syphilis

Tuberculosis

| Relative | Age if alive | Age at death | Ailments |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |
| **Brothers** | | | |
| **Sisters** | | | |
| **Children** | | | |
| **Maternal Grandmother** | | | |
| **Maternal Grandfather** | | | |
| **Maternal Aunts/Uncles** | | | |
| **Paternal Grandmother** | | | |
| **Paternal Grandfather** | | | |
| **Paternal Aunts/Uncles** | | | |

**Is there any other information that I would need to know?**

_____

_____

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Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.) I, the undersigned, understand that Ashley Mendoza is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Ashley Mendoza, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Ashley Mendoza and/or Rose Blanche Wellness which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Patient Signature: _____ Date:_____

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