Name: ____________________

# Vivacious Homeopathy LLC

**C-732-983-2283**

## QUESTIONNAIRE FOR ADULT

| **First name:** | **Last name:** |
|---|---|
| **Date of birth: / /** | **Today's date:** |
| **Address:** | **Sex (Circle):** Male Female |
| **City:** | **Height:** **Weight:** |
| **ZIP:** | |
| **Home Telephone:** | **Work Telephone:** |
| **Cell Phone:** | **Website:** |
| **Emergency contact: (Name, relationship, Address, Tel)** | |
| **E-Mail:** | **Occupation:** |
| **Contact details of Primary doctor:** | |
| **Marital Status (*Circle relevant one*)**<br>Single, Married, Gay, Divorced, Separated, Widowed, Domestic partnership | |

**How did you find out about us? (*Circle all relevant ones*)**
Referral / Friend / Website / Online Search / Brochure / Other
If Other, please specify ---------------------------------------------------------

Thank you for taking the time to fill out this questionnaire. It is designed to help me understand your problem and to understand you as a person. It is also aimed at giving you a greater awareness of your symptoms, making it easier to relay them to me during our consultation.

Looking forward to meeting you!!

**Please type or write neatly.**
**You may email filled-up questionnaire**
**OR bring it along with you during your visit.**

Name: ___________________

THIS REPORT WILL BE TREATED STRICTLY CONFIDENTIAL

## Section A: MAIN COMPLAINT

Please describe your main complaint(s) in as much detail as possible.
Note when it started, what makes it better or worse and what treatments you have tried?

Name: ___________________

## Section B: MEDICAL HISTORY

List any medications/ vitamins/ herbs or supplements you are currently taking:

| DRUG | DOSAGE | INDICATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*Don't forget to bring along any relevant medical records you have available.*

List medicines you have taken frequently in the past or over an extended period of time.

| DRUG | DOSAGE | INDICATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

List any surgeries you have had:

| DATE | SURGICAL PROCEDURE | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Name: ___________________

## Section C: General symptoms

Please **CHECK** the information that applies to you:

1) Are you? Thirsty / Thirst less / Somewhere in between

2) What do you drink? ___________________________________

3) Do you? Sip drinks slowly / Gulp drinks down / Neither

4) Do you prefer drinks that are? Ice cold / Hot drinks / Room temperature

5) Is your appetite? Ravenous / Average / Small / Increased / Decreased

6) Is your body temperature: Too Hot / Too Cold / Can't stand Hot or Cold / Not significant

7) What weather suits you best? ___________________________________

8) Is there any weather that aggravates you? _________________________

9) Is your perspiration? Extreme / Profuse / Average / Slight / Not at all

10) How do you rate your sleep? Good /Fair / Average / Poor

11) Do you Have difficulty falling asleep at night ? Yes / No

12) What is your energy level like? Hyperactive / Good energy / OK energy / No energy

13) When is your energy best? _________________________________

14) When is your energy at its worst? _________________________________

15) Do you suffer from? (Check all that apply)
Constipation / Diarrhea / Hemorrhoids / Gas / Bloating

16) Do you have any pain while urinating? Yes / No

17) Do you suffer from urinary tract infections? Yes / No

Name: ___________________

**<u>Section D:</u> Your commitment to getting well.**
*(Please answer this section as honestly as possible)*

Some of you have had your complaints for a long time. For those longstanding or "chronic" complaints, a level of commitment on your part is needed in order to get well.

1) How long have you had your complaint? ____________________

2) How long are you prepared to commit to homeopathic treatment in order to get well?

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

3) What changes in your diet or lifestyle are you prepared to make in order to get well (if no changes, please say no change)?

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Name: __________________

**<u>Section E:</u> Payment policy:**
Unless arranged ahead of time, payment is expected on the day of your visit. We accept cash, cheque, and all major credit cards.
It's better to pay cash or transfer through Zelle on the number (732-983-2283) as there will be extra charge of 5% on all credit cards.

**<u>Section F:</u> Cancellation policy**
We believe in maintaining respect of time for both our patients and for us. The homeopathic consultation is extremely thorough and takes a significant amount of time. This specific block of time is reserved with you for full, uninterrupted session.
If you cannot keep a scheduled appointment, you must notify us a **minimum of 48 hours** prior to your scheduled time, or you will be charged for the appointment. If your appointment is on Monday, please notify our office no later than noon on the previous Thursday if you can't make it.

I acknowledge that I have read and understood the 48-hour cancellation policy.

________________________________ Signed

____________________ Date

Credit card details:

Card Type: ____________________
Card Number: ______________________________
Expiry date: ______/_______/________
Last 3 numbers on the back of the card: _______
Billing zip code: ___________

Name: ___________________

# General Consent Form for Adult

I, _________________________________, hereby grant, Pratibha Gupta, Homeopathic Consultant, the authority to provide homeopathic care to me.

Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the person, the homeopath regards the mental and emotional as well as physical aspects as important. A minor aggravation or worsening of some symptoms may occur as a part of the general healing process.

Confidentiality: I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: Reasonable suspicion that a client presents a danger to himself or herself or to others.

Consultation: I authorize discussion of my case with other professional homeopaths, should assistance in remedy selection and/or symptom analysis be required for my best interest be served by such a consultation. In doing so, my right to privacy will be protected by withholding my name and all other identifying information.

Consent: I am 18 years of age or older and have voluntarily chosen homeopathic treatment for myself. I understand that Pratibha Gupta, is a homeopath and not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check-ups for myself. I further understand that Pratibha Gupta does not diagnose, treat or prescribe for any particular symptom, disease or condition. I understand that she will work on increasing my general vitality and constitutional strength.

Signature: ________________________________________________________________

Name: ___________________________________________________________________

Date of Birth: _____/_____/_______

Email: ___________________________________________________________________

Phone Number: ____________________________________________________________

Date: _____/_____/_______


Vivacious Homeopathy LLC: Mind and Body Healing

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