

NAME:	DATE OF BIRTH:
ADDRESS:	PHONES:
CITY,STATE, ZIP:	HOME:
EMAIL:	CELL:
SEX: M/ F	WORK:
AGE:	NUMBER OF CHILDREN:
SINGLE/MARRIED/LIVE IN SITUATION	SEX HISTORY (CIRCLE ALL THAT APPLY):
EMERGENCY CONTACT NAME AND PHONE:	SAME SEX/OPPOSITE SEX
	OCCUPATION
REFERRED BY:	

REASON FOR VISIT

ANY CONDITION, EMOTIONAL EVENT, SURGERY OR MEDICATIONS ETC... THAT YOU FEEL HAS CAUSED ANY OF YOUR PROBLEMS? PLEASE DESCRIBE.

LIST OF MEDICATION AND SUPPLEMENTS

MEDICATION	since	reason


ALLERGIES (MEDICINE, FOODS AND ENVIRONMENT)


LIST OF SURGERIES

SURGERY	REASON	DATE

LIST OF INJURIES

TYPE OF INJURY	DATE OF INJURY	LASTING EFFECTS

LIST OF PHYSICAL AND EMOTIONAL PROBLEMS SINCE BIRTH..... IN ORDER

PROBLEM	ONSET/DURATION

OTHER MEDICAL HISTORY

LIST OF VACCINES:	DATE
TETANUS Y/N	
MEASLES/MUMPS/RUBELLA Y/N	
PERTUSSIS Y/N	
FLU Y/N	
SHINGLES Y/N	
MENINGITIS Y/N	
OTHER CHILDHOOD VACCINES Y/N	
PROLONGED USE OF ANTIBIOTICS AND REASON:	
HAV E YOU EVER HAD A TRANSFUSION: Y/N WHAT TYPE: DATE:	
CURRENT WEIGHT: POUNDS	
HAVE YOU LOST WEIGHT RECENTLY (NOT DUE TO DIETING):	
ANY DENTAL PROBLEMS: Y/N WHAT TYPE:	
WHAT TYPE OF EXERCISE DO YOU DO AND HOW OFTEN:	
DO YOU CURRENTLY USE TOBACCO: Y/N HAVE YOU USED IN THE PAST: Y/N	
WHAT KIND (CHEW OR SMOKE):	
HOW MANY PACKS PER DAY:	
HOW MANY YEARS DID YOU USE:	
DO YOU USE DRUGS: HAVE YOU USED IN THE PAST: Y/N	
WHAT DRUGS:	
DO YOU DRINK ALCOHOL: HAVE YOU USED IN THE PAST: Y/N	
WHAT KIND AND HOW OFTEN:	
ARE YOU UNDER THE CARE OF A PHYSICIAN FOR CONVENTIONAL CARE: Y/N	
FOR WHAT CONDITIONS :	
HAVE YOU BEEN TREATED WITH HOMEOPATHIC MEDICINE BEFORE:	
NAME OF HOMEOPATHIC PROVIDER:	
LIST OF REMEDIES YOU HAVE USED WITH SUCCESS:	
LIST OF REMEDIES YOU HAVE USED WITHOUT EFFECT:	

FOR WOMEN ONLY

AGE OF ONSET OF MENSES:
MENSES: REGULAR/ IRREGULAR    SEVERE CRAMPING Y/N    HEAVY/LIGHT    SHORT/LONG LASTING
FIRST DAY OF LAST PERIOD :
NUMBER OF MISCARRIAGE:
NUMBER OF ABORTIONS:
AGE OF MENOPAUSE:

FAMILY HISTORY

RELATIVE	CURRENT AGE (if alive)	PROBLEMS AND AGE OF ONSET	AGE OF DEATH
MOM			
DAD			
GRANDPARENTS MATERNAL PATERNAL			
MATERNAL AUNT PATERNAL AUNT MATERNAL UNCLE PATERNAL UNCLE			
SISTER			
BROTHER			
OTHER			