PATIENT INTAKE FORM

HEIDI BUECKING homeopathy

Patient Information

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

	SINCE	CAUSES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

	SINCE	ANY ADVERSE EFFECTS ON YOU
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

	SINCE	RESULTS
_____	_____	_____
_____	_____	_____

CIRCLE EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses, AIDS/HIV, Alcoholism, Anemia, Anxiety disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold sores, Colitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Gallstones, Goitre, Gonorrhea, Gout, Hay fever, Heart disease, Hepatitis, Herpes genitalia, Influenza, Kidney disease, Leukemia, Malaria, Measles, Miscarriage, Mononucleosis, Mood disorder, Mumps, Parasites, Pleurisy, Pneumonia, Post-partum depression Prostatitis, Rheumatic fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-affected disorder, Sexual abuse, Skin disease, Strep throat, Sinusitis, Stroke, Syphilis, Tonsilitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping cough, Worms, Yellow fever.

ANY OTHER MAJOR CONDITIONS: _____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN? WHICH ONE (S)?

_____

WHAT OPERATIONS HAVE YOU HAD?	WHEN	COMPLICATIONS
_____	_____	_____
_____	_____	_____

HAVE YOU LOST ANY WEIGHT LATELY? HOW MANY POUNDS? _____

WHAT EXERCISE DO YOU DO AND HOW MUCH? _____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO: _____ ALCOHOL: _____

COFFEE: _____ "RECREATIONAL" DRUGS: _____

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN (S)?

WHO	FOR WHAT CONDITIONS?	TREATMENT
_____	_____	_____
_____	_____	_____

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

HOMEOPATH WHEN?

FOR WHAT CONDITIONS?

_____ _____ _____

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE (e.g. ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, ETC.)

_____

ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

_____

_____

Health History of Relatives

Alcoholism, Allergies, Arthritis, Asthma, Cancer, Depression, Diabetes, Epilepsy, Gonorrhea, Gout, Hay fever, Heart disease, Mental Illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS: _____

	AGE IF ALIVE	AGE AT & CAUSE OF DEATH	AILMENTS
MOTHER:			
FATHER:			
BROTHERS:			
SISTERS:			
CHILDREN:			
MATERNAL GRANDMOTHER:			
MATERNAL GRANDFATHER:			
MATERNAL AUNTS/UNCLES:			
PATERNAL GRANDMOTHER:			
PATERNAL GRANDFATHER:			
PATERNAL AUNTS/UNCLES:			

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CASE THAT YOU WOULD LIKE TO MENTION_____

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.