HOMEO WELLNESS CLINIC

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INTAKE QUESTIONNAIRE

Name:	
Address:	City:
Postal Code:	Email:
Home #	Bus # ( )
Referred by:	Blood Type : A B AB O
Date of Birth:	Age:
Weight:	Height:
Occupation:	
Past experience with other practitioners (i.e. Chiropractor/Naturopath/Therapist/Homeopath/Massage etc.)	
List 1 – 5 health goals you would like to attain for yourself, in order of priority: (How long have these been a concern to you?)	
1.	
2.	
3.	
4	

5.
" I haven't felt well since" -
What do you believe, or suspect is the reason for your condition?
Recent diagnosis:
Surgeries: Date:
Past conditions or other health information you would like us to know with dates. Include childhood illnesses: Please use separate sheet or record on back of this sheet if needed.
List any vaccinations that you have had including flu shots. Date?
What physical trauma/accidents have you experienced?
Family Health History:

Mother:				
Father:				
Siblings:				
List any medications you are taking now or have in the past.				
Medication	Reason	How long		
List any supplements you are currently taking:				
Supplements	Amount	How long		
What is your daily consumption of:				
Black Tea	Green Tea	Coffee	Herbal Tea	Alcohol
Water	Fruit juice	Pop	Sugar	Artificial Sweetener
Milk	Cream	Margarine	Butter	Cheese
Do you smoke :				
Now?	In the past?	For how long?	When did you quit?	
Allergies that you know of:				

What foods do you crave?
Exercise:
What kind?
Frequency?
How is your concentration focus?
Bowel movements: # per day?
Type: please circle any applicable ones Strained, loose, soft, hard, very thin, diarrhea, explosive, constipated, undigested food, blood or mucus in stool
What time do you go to bed? What time do you get up?
Fall asleep easily? Restless sleeper?
Wake up during the night? Do you feel rested when waking up?
Do you snore? Do you have sleep apnea?
What position do you sleep in?
Is your weight stable or up and down? Constantly dieting?
Menstrual cycle: Regular? Cramping? PMS? Yeast/Bladder infections? Last period? Birth control pills? Hormone Replacement?
Frequent urination? Prostate enlargement?
Teeth:
Amalgam/silver/Filling: How many? Any removed? & how many & when?
Root Canals? Teeth removed?
Crowns or other metals (braces, retainers, partials)?

Previous occupation(s)?
Do you have a high stress job or stressful relationship situation?
What emotional trauma/events have you experienced?
What do you do to manage / relieve your stress?
What are your hobbies? Now and previous?
Do you use? Any for how long each day?
Cell phone: cordless phone computer
Microwave aluminum cookware electric blanket:
Water bed antiperspirant perfume/ hair spray
Pesticides on lawn/flowers/vegetable garden
Where have you lived?
How old is your home? Remodelling/construction/new carpet/paint?
What could get in the way of your plan of action?

Please check which of the following substances you are currently using:

Alcohol How much? _____ Laxatives How much? _____

Pain Killers How much? _____ Chewing Tobacco? If yes, how much _____

Cigarettes How much? _____ Recreational Drugs? How much? _____

Sleeping Pills How much? _____ Coffee? How much? _____

Tea How much? _____ Supplements/Herbs How much? _____

Others How much? _____

Please check - which of the following have you experienced or are suffering from now:

Abortion	Diabetes	Hypertension	Hepatitis	Hepatitis	Warts
Sexual abuse	Allergies	miscarriage	Epilepsy	Skin disease	Anemia
Gout	Sinusitis	Mental health issues	Cancer	Worms or parasites	Prostatitis
Stroke	Goitre	Sexual abuse	Nose bleeds	Gall stones	Asthma
Tonsillitis	Syphilis	Emphysema	Cold sores	Pneumonia	Leukemia
Liver disease	Tuberculosis	Hypothyroidism	Malaria	Hyperthyroidism	Psoriasis
Back pain	Alcoholism	Kidney disease	Mumps	Hay fever	Circulation
Arthritis	Appendicitis	Chicken pox	Jaundice	Influenza	Migraines
Eczema	Depression	Mononucleosis	Whooping cough	Yellow fever	Gonorrhea
Arthritis	Gastric issues	Recurrent infections	Joint pains	Skin issues	Glaucoma

Please check any of the following ailments which may be present in your family history:

Alzheimer's	Alcoholism	Cancer	Diabetes
Depression	Gonorrhoea	Hypertension	Heart Disease
Hepatitis	Mental health issues	Skin Disease	Syphilis
Tuberculosis	Rheumatism	Epilepsy	Eczema
Paralysis	Bleeding Issues	Kidney/Liver Disease	Asthma

Other: _____

Please specify

Please complete a 3 – 7 days food diary using the food diary sheet:

RELATIONSHIP	AGE	IF DECEASED, AGE AT DEATH	CAUSE OF DEATH	DISEASES
FATHER				
PATERNAL FATHER				
PATERNAL MOTHER				
MOTHER				
MATERNAL FATHER				
MATERNAL MOTHER				
SISTERS				
BROTHERS				
AUNTS				
UNCLES				
CHILDREN				

I, _____of the following address _____

Consent to treatment by Shagufta Karimi at Homeo wellness clinic. I confirm that there has been no suggestion made to me by anyone or control to prevent me from seeking or following allopathic treatment. The decision to seek homeopathic treatment is solely my decision and I understand that I may still seek the treatment of an allopathic doctor or any other health practitioner as needed. This information is provided for a nutritional assessment. I understand that the information I am seeking is for a nutritional nature and not a medical diagnosis

All information disclosed is confidential and remains within the premises of Homeo wellness clinic.

Dated and signed this _____ (day) of _____ (month) _____ (year) _____

Signature_____