Homeopathic Intake Form

Patient

Name: _____ Date: _____
Email: _____ Phone: _____
Address: _____
Medical History: _____

_____

Allergies: _____
Medications: _____

_____

Ailment(s)

Reason for Visit: _____

_____

Symptoms: _____

_____

Starting: _____ Location on Body: _____
Prior Treatments: _____

_____

Modalities: _____

_____

Ameliorators: _____

_____

Major Life Events: _____

_____

Questionnaire

Living Situation: ❑ Alone ❑ With Roommates ❑ Partner ❑ Children ❑ Parents
Employment: _____ Duration: _____
Satisfaction with Relationships: _____ Satisfaction with Job: _____
Major Conflicts: _____

_____

Anxieties: _____

_____

Prior Trauma: _____

_____

How is your sleep? _____

_____

How is your diet? _____

_____

Exercise routine? _____

_____

Reactions to _____
change in temp. _____
or seasons _____