EXPERIENCE HEALING HOMEOPATHY
body mind heart spirit
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TODAY'S DATE ____________________________

NAME ____________________________ BIRTHDATE _______ AGE _____ SEX M F MARITAL STATUS _____

ADDRESS ______________________________ CITY __________________ STATE ______ ZIP ________________

HOME PHONE __________________ WORK PHONE ____________________ CELL PHONE ___________________

e-mail____

OCCUPATION _________________________IF RETIRED, PREVIOUS OCCUPATION________________________

CHILDREN________________ AGE(S)____________________ GENDER(S) _____________________

HOW DID YOU HEAR ABOUT THIS HOMEOPATH?____

PLEASE LIST YOUR HEALTH CONCERNS:

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

HEALTH HISTORY

Please CHECK ANY OF THE FOLLOWING THAT APPLY and NOTE WHAT YEAR THEY STARTED

______	AIDS/HIV Infection	__________	______	Frequent Antibiotic Use	__________	______	Migraine Headaches	__________
______	Allergies	__________	______	Frequent Steroid Use	__________	______	Mononucleosis	__________
______	Anemia	__________	______	Gallbladder Disease	__________	______	Mumps	__________
______	Appendicitis	__________	______	German measles	__________	______	Nervous Breakdown	__________
______	Arthritis	__________	______	Giardia/Parasites	__________	______	Neurological Disorder	__________
______	Asthma	__________	______	Glaucoma	__________	______	Occupational Exposure to Toxins	___
______	Attempted Suicide	__________	______	Gout	__________	______	Prostatitis	__________
______	Bursitis	__________	______	Hayfever	__________	______	Psoriasis	__________
______	Cancer	__________	______	Heart Disease	__________	______	Rheumatic Fever	__________
______	Cataracts	__________	______	Hepatitis	__________	______	Scarlet Fever/Scarlatina	__________
______	Chickenpox	__________	______	Herpes	__________	______	Seizure Disorder	__________
______	Chronic Fatigue Syndrome	________	______	High Blood Pressure	__________	______	Sexually Transmitted Diseases (chlamydia, warts, herpes, gonorrhea, syphilis)	_____
______	Chronic Ear Infections	__________	______	Hives	__________			
______	Colitis / Crohn's Disease	__________	______	Hypoglycemia	__________	______	Sleep apnea	__________
______	Depression	__________	______	Jaundice	__________	______	Stroke	__________
______	Diabetes	__________	______	Kidney Infections	__________	______	Substance Abuse/Addiction	_______
______	Eating Disorder	__________	______	Kidney Stones	__________	______	Thyroid Disease	__________
______	Eczema	__________	______	Liver Disease	__________	______	TIA's (mini-strokes)	__________
______	Edema (Fluid Retention)	__________	______	Low Blood Pressure	__________	______	Tuberculosis (TB)	__________
______	Emphysema	__________	______	Lyme Disease	__________	______	Vaccine Reaction	__________
______	Fibromyalgia	__________	______	Measles	__________	______	Whooping Cough	__________

Other:____