|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **Gender:** |  |
| **Street Address:** |  | **Phone # :** |  |
| **City:** |  | **Email Address:** |  |
| **Postal Code:** |  | **Best to reach me by:** |  |
| **Date of Birth (D/M/Y):** |  | **Occupation:** |  |
| **Current M.D.:** |  | **Last Physical /**  **Check-Up:** |  |
| **Phone Number:** |  |
| **Relationship Status:** |  | **Partners Name:** |  |
| **Children/Ages:** |  | | |
| **Emergency Contact:** |  | **Referred by:** |  |
| **Contact Relation:** |  | **Would you like to subscribe to Paula’s newsletter?** |  |
| **Contact Phone #:** |  |  |  |

**Personal Information**

**Main Complaints (in order of importance to you)**

|  |  |  |
| --- | --- | --- |
| **Complaint** | **Since** | **Cause** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Current Medications & Supplements (please attach a separate form if needed)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name & Dose** | **Since** | **Reason for taking** | **Side Effects** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Are you under any other treatment plans? (Therapy, Chiropractic, Acupuncture…)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Treatment** | **Since** | **For which condition** | **Results** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Lifestyle**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How satisfied are you with your current lifestyle/health?** | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**How much of the following do you consume in a week?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tobacco** | **Coffee** | **Cannabis** | **Alcohol** |
|  |  |  |  |
| **Soda/Pop/Juice** | **Tea** | **Meat/Dairy** | **Pre-processed foods** |
|  |  |  |  |

**Please list the following:**

|  |  |
| --- | --- |
| **Food Cravings:** |  |
| **Food Aversions:** |  |
| **Diagnosed Food Allergies:** |  |
| **General Dietary Restrictions:** |  |

|  |  |
| --- | --- |
| **How many hours of exercise per week?** |  |
| **Types of exercise:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How is the quality and duration of your sleep?** | |  | | |
| **Rate your energy from 1-10** |  | | **Best time of day/night:** |  |

|  |  |
| --- | --- |
| **Are you sexually active?** |  |
| **(Female) Are you on birth control? Type:** |  |

**Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please highlight/bold any of the following symptoms/conditions that you have experienced:** | | | |
| Addiction | Eczema | Lung Disease | Sexually Trans. Infect. |
| Allergies | Heartburn/reflux | Mononucleosis | Shingles |
| Anemia | Heart Disease | Mood Disorder | Stroke |
| Arthritis | Hormone Imbalance | Mental Illness | Thyroid Condition |
| Asthma | Hyper/hypotension | Neurological Disorder | Tuberculosis |
| Cancer | IBS | Parasites | Tumours/Cysts |
| Cold Sores | Infertility/Miscarriage | Prostatitis | Urinary Tract Infection |
| Colitis/Crohn’s | Kidney Disease | Respiratory Infection | Ulcers |
| Diabetes | Leukemia | Seizures | Warts |
| Eating Disorder | Liver Disease | Sexual Dysfunction | Yeast/Thrush/Candida |

|  |  |
| --- | --- |
| **Are there any other major conditions?** |  |
| **Have you “never been well since” any of the above conditions?** |  |

**Please list any surgeries or major injuries:**

|  |  |  |
| --- | --- | --- |
| **Surgery/Injury** | **When?** | **Results/Complications** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Is there anything else that you feel is important to your case?** |
|  |

|  |
| --- |
| **Imagine I wave the magic wand of healing over you and all your symptoms disappear.**  How would you feel, what could you do, how would we know that you have healed? Get creative. |
|  |

**Medical/Professional Waiver**

**PLEASE READ THE FOLLOWING CAREFULLY (*if under 18 years of age, a parent or guardian must sign*.) I, the undersigned, understand that Paula Jeffrey is a Manitoba registered homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice, as needed, for any present and future conditions requiring such care. In consulting with Paula Jeffrey, I am exercising my right to choose an alternative method of treatment for my health and that I remain at liberty to seek care from another qualified healthcare practitioner while under Homeopathic care. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential according to PHIA regulations.**

**Patient Signature:\_****Date: \_\_\_\_\_****\_\_\_\_\_**