Paula Jeffrey, Hom., DSHM., B.A.
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Name:		Date of Birth:
Gender:	Marital Status:	Children:
Occupation:	Address & Postal Code:	
Best to reach me by: ☐E-mail ☐ Phone ☐ Text	Phone #:	Referred by:
Email Address:		☑ I would like to subscribe to Paula's monthly newsletter
Emergency Contact:	Relationship:	Emerg. Phone #:
Present M.D.:	Phone:	
Have you been treated with Homeopathy before?	Homeopath:	
For which conditions?		

Main Complaints (In order of importance to you)

Complaint	Since	Cause

Current Medications

Medication	Since	Adverse Effects

Other Treatments/Regimes

Treatment/Regime	Since	Results

Are you currently under the care of a physician(s)?

Physician	For which conditions?	Treatment

Major Operations/Injuries

Operation/Injury	When	Complications

Age of first menses:	Number of Pregnancies:
Complications:	

Which vaccines have you had?
Any adverse reactions?

Have you had any of the following conditions?

☐Anxiety disorder	☐Bipolar Disorder	☐Vertigo	☐Chlamydia	☐Eczema	☐Arthritis	☐Mononucleosis
☐Addiction	☐Sexual Abuse	☐Concussion	☐Gonorrhea	☐Psoriasis	☐HIV/AIDS	☐Rheumatic fever
☐Alcoholism	☐Asthma	☐Diabetes	☐Herpes	☐Warts	☐Cancer	☐Rubella
☐Depression	☐Emphysema	☐Hyperthyroid	☐Kidney Disease	☐Stroke	☐Chicken Pox	☐Scarlet Fever
☐Eating Disorder	☐Hay Fever	☐Hypothyroid	☐Miscarriage	☐High Blood Pressure	☐Hepatitis	☐Strep Throat
☐Mood Disorder	☐Pleurisy	☐Colitis	☐Prostatitis	☐Low Blood Pressure	☐Influenza	☐Tonsillitis
☐Post-partum Depression	☐Pneumonia	☐Gallstones	☐Syphilis	☐High Cholesterol	☐Leukemia	☐Tuberculosis
	☐Sinusitis	☐Gout	☐Venereal Warts	☐Heart Attack	☐Malaria	☐Typhoid fever
	☐Bronchitis	☐Parasites	☐Abscesses	☐Heart Disease	☐Measles	☐Whooping cough
☐Schizophrenia	☐Epilepsy	☐Worms	☐Cold Sores	☐Anemia	☐Mumps	☐Yellow Fever

Are there any other major conditions?
Are there any of the above conditions after which you have not been totally well again?

How much of the following substances are you using?

Tobacco:	Alcohol:
Coffee:	Recreational Drugs:

How much and what type of exercise do you do?
Have you lost any weight lately? How much?

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Is there any other information that I should be aware of?

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: _____ _____