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| --- | --- |
| Name:      | Date of Birth:      |
| Gender:       | Marital Status:      | Children:      |
| Occupation:      |
| Address & Postal Code:       |
| Cell/Home Phone:      | E-mail:      |
| Work Phone:      | Best to reach me by:[ ] E-mail [ ]  Phone | Referred by:      |
| Present M.D.:      | Phone:      |
| Have you been treated with Homeopathy before?      | Homeopath:      |
| For what conditions?      |  |
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| **Main Complaints** | **(In order of importance to you)** |  |  |  |

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

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| **Current Medications** |  |  |  |

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| --- | --- | --- |
| Medication | Since | Adverse Effects |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| **Other Treatments/Regimes** |  |  |  |  |

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| Treatment/Regime | Since | Results |
|       |       |       |
|       |       |       |
|       |       |       |

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

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| --- | --- | --- |
| Physician | For which conditions? | Treatment |
|       |       |       |
|       |       |       |

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| **Major Operations/Injuries** |  |  |  |  |

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| --- | --- | --- |
| Operation/Injury | When | Complications |
|       |       |       |
|       |       |       |
|       |            |       |
|       |       |       |
|       |       |       |
|  |
| Age of first menses:      | Number of Pregnancies:      |
| Complications:        |

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| --- |
| Which vaccines have you had?       |
| Any adverse reactions?      |
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| **Have you had any of the following conditions?** |  |  |  |  |

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

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| --- |
| 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**?

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| --- | --- |
| Tobacco:      | Alcohol:      |
| Coffee:      | Recreational Drugs:      |

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| --- |
| 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

Allergies

Arthritis

Asthma

Cancer

Depression

Diabetes

Epilepsy

Gonorrhea

Gout

Hay fever

Heart Disease

Mental Illness

Paralysis

Pneumonia

Skin Disease

Syphilis

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?**

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**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 homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Paula Jeffrey, I am exercising my right to choose an alternative method of treatment through which to address my total health. 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. I consent that from time to time I may receive e-mails from Paula Jeffrey and/or Rediscover Wellness, which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_