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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? | | | |  | | | | | |  | | | |  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Main Complaints** | **(In order of importance to you)** |  |  |  | |

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

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| --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | **Current Medications** |  |  |  | |

|  |  |  |
| --- | --- | --- |
| Medication | Since | Adverse Effects |
|  |  |  |
|  |  |  |
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| --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Other Treatments/Regimes** |  |  |  |  | |

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

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

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

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| --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **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  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 |

|  |
| --- |
| 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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_