

PATIENT INFORMATION

DATE:

Name		
Date of Birth		Male/Female (Delete as appropriate)
Address		
Telephone home		
Telephone work		
Telephone mobile		
Email		
Occupation		
Marital Status		
Do you have any children? Please give dates of birth:		

Reason for seeking homeopathic treatment now:

Have you seen a homeopath before?

If yes, for approximately how long?

For what condition were you being treated?

Are you being treated by any other complimentary health practitioners at present? Please give details.

GP's name	
Address	
Telephone	
Current medication (including the contraceptive pill, vitamins, supplements):	
Give details of any allergies:	



PERSONAL HEALTH HISTORY

Please fill in this section giving as much information as possible, including dates or your age at the relevant points in time.

Childhood Infectious diseases:
Vaccinations and any adverse reactions:
Major surgical procedures:
Accidents and injuries:
Please describe your preference for a particular type of weather or environment. For example, do you feel best on a cool, foggy day? Does strong sunlight aggravate you? Do you prefer to be in a warm room with the windows closed?
Please describe any food or drink which you strongly desire or dislike. Do any foods upset you?
Do you drink alcohol? If yes, how much?
Do you smoke? If yes, how much?
Do you have any strong fears or phobias?

FAMILY MEDICAL HISTORY

Please describe any diseases suffered by members of your family, even if they are not serious, and any known causes of death.

Mother	Father
Brothers/Sisters	
Aunts/Uncles	Aunts/Uncles
Maternal Grandmother	Paternal Grandmother
Maternal Grandfather	Paternal Grandfather

