

## NEW CLIENT INTAKE AND HEALTH FORM

### PERSONAL INFORMATION

NAME \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
SEX M F  
MARITAL STATUS S M D W  
OCCUPATION \_\_\_\_\_

### CONTACT INFORMATION

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_  
ZIP CODE \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

### PRIMARY CARE PHYSICIAN INFORMATION

NAME \_\_\_\_\_  
TELEPHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_

## NEW CLIENT INTAKE AND HEALTH FORM

### YOUR HEALTH HISTORY

Please list all medications you are currently taking, including birth control and any dietary supplements.

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Please list any medications you have taken in the past.

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Please list any present or prior illnesses, including asthma, neurological disorders, cancer, pneumonia and sexually transmitted diseases.

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Surgeries and hospitalizations (please include approximate dates):

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Vaccinations:

DPT  POLIO  HEPATITIS  MMR  FLU  OTHER \_\_\_\_\_  
(please specify)

Did you notice any effects after vaccination? If so, please include here:

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## NEW CLIENT INTAKE AND HEALTH FORM

### FAMILY HISTORY

Has any blood relative experienced any of the following? Please indicate their relationship to you:

- |   |   |
|---|---|
| _____ <input type="checkbox"/> Alcoholism           | _____ <input type="checkbox"/> GI Ulcer             |
| _____ <input type="checkbox"/> Allergies            | _____ <input type="checkbox"/> Glaucoma             |
| _____ <input type="checkbox"/> Anemia               | _____ <input type="checkbox"/> Hay Fever            |
| _____ <input type="checkbox"/> Arthritis            | _____ <input type="checkbox"/> Heart Disease        |
| _____ <input type="checkbox"/> Asthma               | _____ <input type="checkbox"/> Hyper/Hypothyroidism |
| _____ <input type="checkbox"/> Auto-immune Disorder | _____ <input type="checkbox"/> Mental illness       |
| _____ <input type="checkbox"/> Cancer               | _____ <input type="checkbox"/> Narcolepsy           |
| _____ <input type="checkbox"/> Depression           | _____ <input type="checkbox"/> Rheumatism           |
| _____ <input type="checkbox"/> Diabetes             | _____ <input type="checkbox"/> Stroke               |
| _____ <input type="checkbox"/> Drug Addiction       | _____ <input type="checkbox"/> Suicide              |
| _____ <input type="checkbox"/> Eczema               | _____ <input type="checkbox"/> Tuberculosis         |

I, \_\_\_\_\_ (client) understand that homeopaths are not medical doctors. Any decisions to reduce or change my allopathic medications will be made between my medical doctors and myself.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE