NEW YORK
HOMEOPATHY

80 EAST 11TH ST SUITE 208 NEW YORK NY 10003
NY-HOMEOPATHY.COM

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 _____

ERIKA SIMONIAN
347 307 3035
ERIKA@NY-HOMEOPATHY.COM

KAREN LAWSON
646 402 5358
KAREN@NY-HOMEOPATHY.COM

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YOUR HEALTH HISTORY

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

_____

_____

_____

Please list any medications you have taken in the past.

_____

_____

_____

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

_____

_____

_____

Surgeries and hospitalizations (please include approximate dates):

_____

_____

_____

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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FAMILY HISTORY

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

_____	☐ Alcoholism	_____	☐ GI Ulcer
_____	☐ Allergies	_____	☐ Glaucoma
_____	☐ Anemia	_____	☐ Hay Fever
_____	☐ Arthritis	_____	☐ Heart Disease
_____	☐ Asthma	_____	☐ Hyper/Hypothyroidism
_____	☐ Auto-immune Disorder	_____	☐ Mental illness
_____	☐ Cancer	_____	☐ Narcolepsy
_____	☐ Depression	_____	☐ Rheumatism
_____	☐ Diabetes	_____	☐ Stroke
_____	☐ Drug Addiction	_____	☐ Suicide
_____	☐ Eczema	_____	☐ 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

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