

Client's Name _____ **DOB** _____

Parent(s) _____

Address _____

City/State/Zip _____

Phone (primary) _____

Phone (other) _____

Email: _____

Family History

Do parents or grandparents have the following conditions? Check those that apply

- | | |
|-----------------------------|------------------------------|
| Alcoholism | Herpes |
| Allergies | High Blood Pressure |
| Anemia | Lymes Disease |
| Arthritis | Mental disorder |
| Asthma | Migraine |
| Auto Immune Disorder | Narcolepsy |
| Bleeding | Rheumatism |
| Cancer | Scoliosis |
| Diabetes | Stroke |
| Drug addiction | Suicide |
| Eczema/Psoriasis | Thyroid Trouble |
| Gastro-intestinal disorders | Tuberculosis |
| Genetic defects | Sexually Transmitted Disease |
| Glaucoma | |
| Gonorrhea | other or past illness: |
| Hay Fever | accidents-injuries: |
| Heart Disease | |

Vaccinations:

Current medications

Chief Complaint (s):

Today's Date:

Classical homeopathy is used to increase my general energy and constitutional vitality to overcome illness. It is an approach that utilizes remedies that stimulate the body's own immune and defense system to initiate the healing process. Remedies are individualized according to the totality of the person's physical, emotional, and mental symptoms and bring about deep healing on all levels. Classical homeopathy should not be confused with 'over the counter homeopathic products', herbal remedies, or the broad field of dietary and natural medicine.

- ***I voluntarily choose homeopathic care for myself, my child(ren) or ward(s).***
- ***I understand the homeopath is not a licensed medical doctor, physician.***
- ***I have the opportunity to ask questions about things I did not understand about Classical Homeopathy.***
- ***If I have a medical complaint or question about my disease or that of my child(ren) or ward(s), I will consult with a physician or medical doctor.***
- ***If I wish to discontinue any pharmaceutical medications, will do so under the supervision of a medical doctor trained in the use of the kinds of medication I am taking.***
- ***I understand that the homeopath does not diagnose, treat, prevent or prescribe for any disease.***
- ***I represent that I have authority to make health care decisions for my child/ward, and in my judgment it is in the child's or ward's best interest to receive homeopathic care, and that if I have any concerns or questions whatsoever about my child's medical condition, I will take my child/ward to a competent physician in a timely manner.***
- ***I understand that Consent refers to the client, or me, and also refers to my child or ward, as appropriate.***

Signature

Date

Name (Print)

Name of Child/ward (Print)