Homeopathic Consultation Form

Name:_____ Date of Birth: D_____ M_____ Y_____

Address:_____
Street City Postal code

Telephone: Home:_____ Work_____ Other_____

E-mail address:_____

Referred By:_____ Present M.D. and Phone no.:_____

Major Complaints in Order of Importance For You:

Complaint	Since	Causes

Which Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments or Regimes Are You Currently Following?

Treatment or Regime	Since	Results

Which Of The Following Conditions Have You Had?

Abscesses	Alcoholism	Allergies	Amnesia	Anemia	Asthma	Cancer
Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Emphysema	Epilepsy
Gall Stones	Goitre	Gonorrhea	Gout	Hay Fever	Heart Disease	Hepatitis
Herpes Genitalia		Influenza	Kidney Disease	Leukemia	Malaria	Measles
Miscarriage	Mononucleosis	Mumps	Parasites	Pelvic Inflammatory Disease		Peritonitis
Pleurisy	Pneumonia	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sun Stroke	Syphilis	Tonsillitis
Tuberculosis	Typhoid Fever	Venereal Warts	Warts	Whooping Cough	Worms	
Yellow Fever						

Any Other Major Conditions?_____

Are there any of the preceding conditions after which you have not been totally well again? Which Ones?

_____

_____

Age of first Menses:_____ Number of Pregnancies:_____

Are You Currently Under the Care of a Physician(s)?

Physician	For What Condition?	Treatments
_____	_____	_____
_____	_____	_____

What Major Operations Have You Had?

Operation	When	Complications

What Major Injuries Have You Had?

Injury	When	Complications

Vaccination History/Childhood Illness:

Measles	Yes	No	Any Adverse Effects from any of these Vaccinations?:
Mumps	Yes	No	_____
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	_____
Whooping Cough	Yes	No	

How Much of the Following Substances Are You Using?

Tobacco_____Alcohol_____Coffee_____Recreational Drugs_____

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	Heart Disease	Insanity	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 would need to know?

_____

_____

Medical/ProfessionalWaiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Angelica Necula 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 Angelica Necula, 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 agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Patient Signature:_____ Date:_____

Witness:_____

All clients are required to agree to the following Release and Liability Waiver which is effective for all visits.

By signing below, I acknowledge and agree that:

- Homeopaths do not diagnose conditions.
- The sole purpose of homeopathic remedies is to balance, harmonize, release and heal on all three levels (physical, mental, emotional).
- I understand that some bodily functions may temporarily energetically be affected as a result of shifting energy within my body and I agree that this is a natural occurrence (E.g. feeling more tired) or heighten current symptoms (totally normal body reaction, as part of the healing process), or old symptoms coming back to the surface.
- Treatment/s will not replace conventional medical diagnosis or treatment. I will continue taking medication prescribed by a licensed medical physician and will continue to follow his/her instructions.
- I release the homeopath from all legal liability during my participation in Homeopathic treatment/s.
- All information received by me from the homeopath is accepted with full knowledge that any action taken by me as a result of the information received is my complete responsibility.

Please Print Name_____Signature

Address_____

Date _____Email_____

Ph # _____Recommended by_____

Angelica Necula, Homeopath (HOM)
www.healnow.ca