

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE: (H) _____ (W) _____ EMAIL: _____

OCCUPATION: _____

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

_____ SINCE: _____
_____ SINCE: _____
_____ SINCE: _____
_____ SINCE: _____
_____ SINCE: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | | |
|-------------|------------|----------------|---------------|-----------------|----------------|
| Abscesses | Depression | Heart Disease | Mononucleosis | Rheumatic Fever | Syphilis |
| Alcoholism | Diabetes | Hepatitis | Mumps | Rubella | Tonsillitis |
| Allergies | Emphysema | Genital Herpes | Parasites | Scarlet Fever | T.B. |
| Amnesia | Epilepsy | Influenza | Peritonitis | Sexual Abuse | Typhoid Fever |
| Arthritis | Gallstones | Kidney Disease | Pleurisy | Strep Throat | Venereal Warts |
| Asthma | Goitre | Leukemia | Pneumonia | Sinusitis | Warts |
| Cancer | Gonorrhea | Malaria | Prostatitis | Sunstroke | Whooping Cough |
| Chickenpox | Gout | Measles | Stroke | Ulcers | Yellow Fever |
| Other _____ | | | | | |

ARE THERE ANY CONDITIONS OR EVENTS AFTER WHICH YOU HAVE NOT BEEN WELL SINCE?

ARE YOU TAKING ANY MEDICATIONS?

_____ SINCE: _____
_____ SINCE: _____
_____ SINCE: _____

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE? PLEASE LIST PHYSICIAN, CONDITION AND REMEDIES:

WOMEN: AGE AT FIRST MENSES: _____ NUMBER OF PREGNANCIES: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD (TYPE , DATE AND ANY COMPLICATIONS):

ARE YOU CURRENTLY FOLLOWING ANY OTHER TREATMENTS? PLEASE LIST TYPE, PHYSICIAN AND CONDITION.

HAVE YOU HAD ANY VACCINATIONS? PLEASE LIST TYPE, APPROXIMATE DATES AND ANY ADVERSE EFFECTS:

HAVE YOU HAD ANY MAJOR INJURIES? PLEASE LIST TYPE OF INJURY, DATE AND ANY LONG TERM EFFECTS:

PLEASE CIRCLE WHICH OF THE FOLLOWING SUBSTANCES YOU HAVE USED OR CURRENTLY USE INCLUDING AMOUNT: Tobacco Coffee Alcohol Recreational drugs

PLEASE INDICATE ANY SENSITIVITIES YOU MAY HAVE (IE: ENVIRONMENTAL, MEDICATION, CHEMICAL ETC):

PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS ARE IN YOUR FAMILY HISTORY AND INCLUDE ANY OTHER MAJOR AILMENTS.

Alcoholism	Allergies	Anxiety	Arthritis	Asthma	Cancer	Depression
Diabetes	Drug abuse	Gonorrhea	Gout	Hay fever	Heart disease	Paralysis
Pneumonia	Skin disease	Syphilis	TB			

RELATIVES:

CONDITIONS:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Maternal Aunts/Uncles: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Paternal Aunts/Uncles: _____

DECLARATION & CONSENT:

I, _____, hereby consent to treatment by Wellness Within Reach, and understand and acknowledge that I have the option of seeking/continuing conventional medical treatments and services if I choose to do so.

Notification of any cancellations are required 24 hours in advance, otherwise half fee of missed appointment applies. I agree to pay the fee of each visit in full at the end of each visit.

Signature: _____ Date: _____