

Homeopathy Adult Questionnaire

Name:
Marital/Relationship Status:
Address:
Phone:(day) (eve)
Referred by:
E-mail address:
Date: DOB: Age:
Height: Weight:

- What is your chief complaint (CC)?
- When did this problem start? What was happening in your life around that time? What do you think could cause the problem?
- What makes this problem worse? (E.g. certain types of foods or weather, movement, light, noise, heat/cold or anything else that you can think of; please be specific)
- At what time of the day or night you feel your problem the most? Specify the hours if you can.
- Are there any other symptoms or conditions that accompany your main problem?

HEALTH HISTORY

- What medications are you taking at present?
- Did you have any childhood illnesses twice, or in a very severe form or any that came after puberty?

- How frequently do you get colds and flu?
- When last time you had high fever? How high?
- Did you have any vaccinations after the standard childhood ones?
- Did you ever have an adverse or unusual reaction to a vaccination?
- Did you have any surgeries? What kind and when?
- Did at any time of your life you had following (please mention the year): What therapy was given?
 - a) Warts: where? when? how treated?
 - b) Cysts: where? when? how treated?
 - c) Polyps: where? when? how treated?
 - d) Tumours: where? when? how treated?
- Do you have now or had at any time of your life any discharges (nasal, vaginal, urethral)? Please mention colour, consistency:
- Please describe your sensitivity to external factors:
 - a) Do you tend to need a smaller dose of medications than most of other people?
 - b) Do you need less anaesthesia than others people or have a hard time coming out of it?
 - c) Do you tend to react to vitamins and herbs and/or need hypoallergenic vitamins?
 - d) Are you sensitive to paint fumes, exhaust, dry cleaning fluids, fragrances etc.?

Family History

Please mention diseases, causes and ages of deaths of father, mother, sisters, brothers and grandparents on both sides



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DECLARATION AND CONSENT:

Collection, use and disclosure of information

We are committed to collect, use and disclose your personal information responsibly

We collect, use and disclose information about you for the following purposes

- Assessment of your health needs, in order to provide safe and effective homeopathic health care
- Establishment of effective communication with you
- Communication with other health care providers, if necessary
- Compliance with legal and regulatory requirements
- Advice about other treatment options

We are ensuring that:

- Only those that are necessary for your care are collected
- Your medical records are safeguarded
- Your information is disclosed to third party only with your expressed consent, or when necessary for legal reasons

I, _____ of following address,

_____, acknowledge and declare that I have an option of seeking/continuing allopathic (conventional) medical care from medical doctor and that homeopathy and conventional medicine are different, but not mutually exclusive. I confirm that there has been no suggestion made to me by Homeopath Veronika Zhmurko or anyone under her direction or control that I should refrain from seeking or following allopathic medical treatment. I am aware that due to differences in patient's mental and physical conditions and lifestyle the results of homeopathic treatment may vary. Therefore, I hereby authorize my consent to treatment by Homeopath Veronika Zhmurko. I agree to pay my account after every visit, unless other arrangements have been made. I reviewed the information above about the use of my personal information. I agree that Homeopath Veronika Zhmurko may collect, use, and disclose information about me as set out in the office privacy policy.

Signature: _____

Date: _____