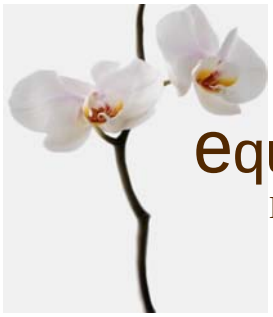

equilibrium
HEALING

Adult Intake Form

(Please Print)

PATIENT INFORMATION

Today's date:				
Last name:	First:	Middle:	Mr. Mrs. Miss Ms.	Marital status:
Birth date: dy / mth /yr	Age:	Sex: male fem		
Street address: P.O. box:		Home phone no.: ( )		Other phone no.: ( )
City:	Province:		Postal Code:	
Occupation:	Employer:			Employer phone no.: ( )

Referred to clinic by (please check one box):			Family	Friend	o
Hospital	Insurance Plan	Close to home/work	Internet	Lecture/Workshop	
Name and phone no. of Family Physician:					
Name and phone no. of Homeopath (if you have previously seen one):					

IN CASE OF EMERGENCY

*Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Vital Statistics

Height:	**Weight:**	**Blood Pressure:**	**Pulse:**	**Date of Last menstrual period:**
Age of first menses:	**# Pregnancies?**	**# Miscarriages or Abortions:**		
Allergies:				

HEALTH HISTORY

*

What is your main health concern? When did it start?

Did this concern start after an event, accident or mental upset? Such as shock, worry, dietary, overexertion, weather?

Does anything make it better or worse?

Do you have any other health concerns? Please list in order of importance for you.

Please check if you have **ever** had any of these conditions:

Abscesses
Alcoholism
Anemia
Appendcitis
Arthritis
Asthma
Cancer
Chicken pox
cold sores
Depression
Diabetes
Eczema
Epilepsy
Emphysema
Gall stones
Goitre
Gonorrhoea
Gout
Headaches
Heart trouble
Hypertension
Hepatitis
Herpes
Influenza
Jaundice
Kidney disease
Leukemia
Liver disease
Malaria
Measles
Mental illness
Mononucleosis
Mumps
Nosebleeds
Parasites
Pelvic inflammatory disease
Pneumonia
Prostate disease
Rheumatic Fever
Sexual abuse
Skin disease
Strep throat
Sinusitis
Stroke
Syphilis
Tonsillitis
Tuberculosis
Venereal warts
Warts
Whooping cough
Worms
Yellow fever

Others?

P*ease describe any major surgeries. When? Complications?

P*ease list all drugs, medications or supplements which you are currently taking, the *reason and the effect.

List all the vaccinations you have had and any adverse reactions.

LIFES*YLE

Check (any of the following that you currently use and indicate how often you use them or how long you have been using them)

laxatives_____	Birth Control Pill_____	*Alcohol_____	Recreational Drugs_____
cortisone_____	Pain Relievers_____	Aspirin_____	Anti-*depressants_____
Tabacco_____	Sleeping Pills_____	Antacids_____	

What exercise do you do and how much?

Are you regularly exposed to toxins or other hazards (home, work, hobbies, etc.)? Please describe:

FAMILY HISTORY

Please check which ailment has affected you family and who was affected:

Alzheimer's	Epilepsy	Skin diseases
Alcoholism	Gonorrhoea	Syphilis
Asthma	Hypertension	Tuberculosis
Arthritis	Heart disease	Ulcers
Cancer	Hepatitis	Others
Diabetes	Mental illness	
Depression	Pneumonia	

Thank you for taking the time to fill out these forms.
All your information is confidential.
We look forward to working with you on your journey to health and wellbeing.

EQUILIBRIUM-HOMEOPATHY