

Kathryn Final, DSHomMed, FCHM, RCSHom, RYT

Registered Homeopath

Phone: 778-873-4750 / Email: finalhomeopathy@gmail.com

Homeopathy Intake Form:

Note to Patient: Determining the proper remedy involves investigating and evaluating all of the subjective and objective symptoms that you are experiencing in the context of your individual life, circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation the most effective, I request that you complete the following information form as in-depth and accurately as possible. All information is kept in strict confidence. If you have any questions please do not hesitate to contact me. Please use the back of the page if more space for answers is needed.

| | |
|------------------------|-----------------------------------|
| First Name: | Last Name: |
| Address: | City/Province/Postal Code: |
| Home Phone: | Cell Phone: |
| Email: | Date of Birth: |
| Sex: | Height: |
| Weight: | Hair/Eye colour: |
| Marital Status: | Occupation: |
| Family Doctor: | Phone Number: |
| Fax: | Email: |
| Address: | City/Province/Postal Code: |

Medical Complaints / Reasons you are seeking Homeopathic Treatment (please list in order of importance to you):

1.

4.

2.

5.

3.

6.

Medical History:

Immunizations (please circle all those you have had):

Diphtheria

Hep A / B / C

Polio

Whooping Cough

Tetanus

Mumps / Measles / Rubella

Other (please specify):

Have you had any adverse reactions to vaccinations? If yes, please explain:

Do you have allergies? If yes, please list along with any medications you may be taking:

Have you ever suffered from or do you currently suffer from:

| | | | |
|-------------|-------|----------------------------|-------|
| Alcoholism: | Y / N | High / Low Blood Pressure: | Y / N |
| Abortion: | Y / N | Miscarriage: | Y / N |
| Depression: | Y / N | PMS: | Y / N |
| Drug abuse: | Y / N | Sexual Abuse: | Y / N |

Do you use the following (please circle all that apply):

| | | | |
|--------------------|-------|-----------------------|-------|
| Alcohol: | Y / N | Fried Foods: | Y / N |
| Antacids: | Y / N | Laxatives: | Y / N |
| Carbonated drinks: | Y / N | Margarine: | Y / N |
| Coffee: | Y / N | Non-sugar sweeteners: | Y / N |
| Filtered water: | Y / N | Salt: | Y / N |
| Fast foods: | Y / N | Sweets/Sugar: | Y / N |
| Tea: | Y / N | Tobacco: | Y / N |
| Marijuana: | Y / N | Wheat: | Y / N |
| Dairy: | Y / N | | |

Please list any pharmaceutical drugs and/or nutritional supplements you are taking (vitamins, herbs, etc.) Use back of page for longer lists:

What medications have you taken in the last year?

What surgeries have you had during the course of your life?

What major injuries have you had during the course of your life?

Have you suffered from the following conditions? (Please circle all that apply)

| | | |
|----------------|-----------------------------|----------------|
| Abscesses | Influenza | Rubella |
| Anemia | Kidney Disease | Scarlet Fever |
| Arthritis | Leukemia | Skin Diseases |
| Asthma | Lyme Disease | STDs |
| Cancer | Malaria | Sinusitis |
| Chicken Pox | Measles | Strep Throat |
| Cold Sores | Mononucleosis | Stroke |
| Diabetes | Multiple Sclerosis | Sunstroke |
| Eczema | Mumps | Tonsillitis |
| Emphysema | Parasites | Tuberculosis |
| Epilepsy | Pelvic Inflammatory Disease | Typhoid Fever |
| Frequent Colds | Peritonitis | Venereal Warts |
| Gallstones | Pleurisy | Warts |
| Gout | Pneumonia | Whooping Cough |
| Heart Disease | Prostatitis | Worms |
| Hepatitis | Psoriasis | Yellow Fever |
| HIV | Rheumatic Fever | |

Other conditions not listed here:

Has there been any grief, shock or traumas that have affected you in the past or present?

Have you ever been treated homeopathically before? If yes, please list for what conditions, the remedies prescribed and if they were helpful?

Family Medical History:

| Family Member | Conditions | Age (if alive or of death) |
|----------------------|------------|----------------------------|
| Mother | | |
| Father | | |
| Sister (s) | | |
| Brother (s) | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Aunts, Uncles | | |

Tips on observing your symptoms and reporting them for Homeopathic Purposes (if it helps, write/outline on the back of the page) These are the kinds of questions you will be asked in the initial consultation:

- 1) Describe in detail, the onset of your symptoms. Outline any related mental, emotional or physical symptoms and/or any external conditions that may have contributed to your state of being at that time.
- 2) Outline all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these ailments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?
- 3) Describe any symptom you are experiencing in terms of its location in the body. Does this symptom shift from one place in your body to another? Are there related symptoms elsewhere in the body? Particular sensations associated with the symptoms? How does it feel/look/smell/taste? Is there anything that makes the symptom unique, striking or unusual? If pain is involved, describe the pain you endure such as a dull ache vs. a stabbing pain, a constant or periodic pain, etc. Describe the onset of your pain; slow vs. sudden? How intense is the pain (on a scale of 1 to 10 - 10 being the most painful)?
- 4) Write down when your symptoms feel better or worse: time of day/ when hot or cold/ month/ season/ before or after eating / sleep/ moving / resting/ certain positions / when occupied / specific mental or emotional states.
- 5) Are you affected in any way by different kinds of weather? Dryness / humidity/ approaching storms/thunderstorms / frost/ cloudiness / low or high altitudes / being by the seashore.
- 6) Urination (if of concern): color / odor / sediment / quantity / frequency / urgency.
- 7) Stool (if of concern): color/ odor/ sediment / quantity/ frequency / urgency.
- 8) Menses: length of cycle / length of period / significant pain associated with menses / nature of the flow / clotting / cramping / PMS / mood swings / bloating / swollen tender breasts / cravings / vaginal discharge with or without menses.
- 9) Sex: Desires / aversion / painful intercourse / vaginal dryness / impotency.
- 10) Perspiration: profuse / scanty (little) / odor.
- 11) Body Temperature: Hot vs. Cold body type / hot or cold hands or feet / hot flashes.
- 12) Sleep: do you wake up at night? What time? How do you feel in the morning on rising? What position do you sleep in the most? Are parts of the body covered or exposed when sleeping? What kinds of dreams do you have? Do you have any recurring dreams or nightmares? Do you have trouble falling asleep and/or staying asleep?
- 13) What motivates you in life? Are there lasting traits from childhood that are still an issue today? Are there running themes in your life? Eg "All my life I've been..." How would others describe you? How do you deal with change in your life? Do you need structure in your life?

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Informed Consent to Treatment

I, _____, the undersigned understand that Kathryn Final is not a medical doctor, but instead a **Registered Homeopath**. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Kathryn Final, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future conditions. I also reserve the right to terminate homeopathic treatment at any time, if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its totality. All information from the intake form, medical records and what is discussed in the sessions, will be kept in strict confidentiality.

I understand that this form of medical care is based on alternative and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. Homeopathic medicine is safe, gentle and non-toxic, however an aggravation of existing or pre-existing conditions may occur as part of the healing process. I understand that it is my responsibility to inform Kathryn Final of any of these aggravations, and to generally notify her of any concerns, should they arise throughout the treatment.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

FEE SCHEDULE:

I agree to pay all fees incurred as presented in the current rate schedule below, (rates are subject to change).

INITIAL CONSULTATION: **\$130.00** (1.5 – 2 hours approx.)

FOLLOW UP VISITS: **\$75.00** (45 minutes approx.)

Please Note:

- All fees are payable at the end of each consultation in cash or e-transfer only. A receipt will be provided for insurance or record keeping purposes, if requested.

Patient's Signature _____ **Date:** _____

(If under 18 years of age, a parent or guardian must sign on your behalf)