



K-W HOMEOPATHIC MEDICINE AND WELLNESS CLINIC

NEW PATIENT INFORMATION

*All information provided is kept in strict confidence

Name: _____ Date: _____

Address: _____

Telephone: (home) _____ (cell) _____ (work) _____

E-mail: _____

Emergency contact: (name) _____ (relationship) _____

telephone: (home) _____ (cell) _____

Primary care physician: (name) _____ (telephone) _____

Address: _____

Referred by: _____

Occupation: _____

Date of Birth: _____ **Age:** _____ **Sex:** male female

Weight: _____ **Height:** _____

Marital Status: single married divorced widowed

Number of children, if any: _____ **Number of pregnancies:** _____

Female Patients: Age at first period: _____



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Main concerns, in the order of priority, and date started:

Can you trace the origin of any present condition to any particular circumstance? (e.g. accident, illness, grief, mental upset, etc.)

Prescription medications, non-prescription medications and health supplements you are currently taking:

Name	Dosage	Condition treated	Since when

Other treatments or therapies:

Name	Frequency	Since when

Substances you are using:

Description	Amount	Description	Amount
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Pain Killers	
<input type="checkbox"/> Chewing Tobacco		<input type="checkbox"/> Recreational Drugs	
<input type="checkbox"/> Cigarettes		<input type="checkbox"/> Sleeping Pills	
<input type="checkbox"/> Coffee		<input type="checkbox"/> Tea	
<input type="checkbox"/> Laxatives / Purgatives		<input type="checkbox"/> Other	

Allergies: _____



Medical history

Medical procedures, surgeries, hospitalizations, accidents and major trauma

Date	Description

<p>Vaccinations:</p> <p><input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Pertussis <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Flu <input type="checkbox"/> Other</p> <p>Adverse reactions: _____</p>
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Which of the following have you experienced or are you suffering from now:

<input type="checkbox"/> Abortion	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal warts
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mental problems	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Warts
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Worms
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Yellow Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goitre	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Parasites	<input type="checkbox"/> Syphilis	Other:
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Gout	<input type="checkbox"/> Leukaemia	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/>
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Malaria	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Urticaria	<input type="checkbox"/>

Your mother's pregnancy – give details about:

Problems _____

Drugs _____

Difficulty about your birth? _____



Family history:

Ailments which may be present in your family history:

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mental problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin Disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Syphilis	

Relationship	Age	Diseases	Age at death	Cause of death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				
Maternal Grandmother				
Grandfather				
Aunts				
Uncles				
Paternal Grandmother				
Grandfather				
Aunts				
Uncles				



Details about your Symptoms:

What triggers your symptoms (mental, emotional and physical symptoms)?

Does anything make your symptoms unique?

What makes your symptoms better (i.e. hot/cold, eating, sleep, time of day)?

What makes your symptoms worse?

Are you affected by the weather? How?

Perspiration (odour, night sweats, profuse)?

Body temperature:

Sleep (falling asleep, waking, position):

Average energy level during the day (0 = none, 10 = max.): _____

Have you lost any weight recently? How much? _____

Are there any themes running through your life, e.g. all my life.....?



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Is there anything else regarding your overall condition that we should know?

Do you give permission to share your information with your other health care providers for purposes of medical evaluation?

yes no

Would you like to receive periodic information on specials?

yes no

(signature)

How did you hear about K-W Homeopathic Medicine and Wellness Clinic?

- Referral from Health Care Practitioner
- Referral from family or friends
- Public Health Talk
- St. Jacobs Farmers' Market
- Other
- Internet _____
- Newspaper _____
- Magazine _____
- Event _____

Thank you for taking the time to fill out this form!