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: _____

27 Pennsylvania Crescent
Kitchener, ON
N2P 2S5

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Tel.: (519) 603-0505
or visit our website at:
www.kwhomeopathicmedicine.com

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**
□ **Alcohol**		□ **Pain Killers**	
□ **Chewing Tobacco**		□ **Recreational Drugs**	
□ **Cigarettes**		□ **Sleeping Pills**	
□ **Coffee**		□ **Tea**	
□ **Laxatives / Purgatives**		□ **Other**	

Allergies: _____

_____

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Medical history

Medical procedures, surgeries, hospitalizations, accidents and major trauma

Date	Description

Vaccinations:

□ **Measles** □ **Mumps** □ **Rubella** □ **Pertussis** □ **Chicken Pox** □ **Flu** □ **Other**

Adverse reactions:_____

Which of the following have you experienced or are you suffering from now:

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

Your mother's pregnancy – give details about:

Problems _____

Drugs _____

Difficulty about your birth? _____

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Family history:

Ailments which may be present in your family history:

□ **Alzheimer's**	□ **Diabetes**	□ **Hypertension**	□ **Mental problems**	□ **Tuberculosis**
□ **Alcoholism**	□ **Depression**	□ **Heart Disease**	□ **Skin Disease**	
□ **Cancer**	□ **Gonorrhoea**	□ **Hepatitis**	□ **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				

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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!

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