OSTEOPATHIC HEALTH CENTRE
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ADULT HOMEOPATHIC CONSULTATION FORM

Name: ____ Date of Birth: (D) _______ /(M) ________ /(Y) ________

Address: ____
Street City Postal code

Telephone: Home: ______________________ Work: _____________________ Mobile: ___________________

E-mail address: ____

Referred By: ______________________ Family Doctor & Phone no.: _____________________________________

Major Complaints in Order of Importance For You:

Complaint	Since	Causes

Which Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments or Regimes Are You Currently Following?

Treatment or Regime	Since	Results

Please Circle Any Of The Following Conditions You Have Had?

Abscesses	Alcoholism	Allergies	Amnesia	Anemia	Arthritis	Asthma
Cancer	Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Emphysema
Epilepsy	Gall Stones	Goitre	Gonorrhea	Gout	Hay Fever	Heart Disease
Hepatitis	Herpes	Influenza	Kidney Disease	Leukemia	Malaria	Measles
Miscarriage	Mononucleosis	Mumps	Parasites	Pelvic Inflammatory Disease		PCOS
Pleurisy	Pneumonia	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sun Stroke	Thyroid issues	Tonsillitis
Tuberculosis	Warts	Whooping Cough	Worms	Yellow Fever		

Any Other Major Conditions? ____
Are there any of the preceding conditions after which you have not been totally well again?
Which Ones? ____

____
(Women) Age of first Menses: __________________ (Women) Number of Pregnancies: ___________________________

Are You Currently Under the Care of a Physician(s)?

Physician	For Which Condition?	Treatments
________________________	______________________________________	___________________________
________________________	______________________________________	___________________________

What Major Operations Have You Had?

Operation	When	Complications

What Major Injuries Have You Had?

Injury	When	Complications

How Much of the Following Substances Are You Using?

Tobacco ____________ Alcohol _____________ Coffee _______________ Recreational Drugs ______________

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes
Epilepsy Gonorrhea Gout Heart Disease Insanity Paralysis Pneumonia
Skin Disease Syphilis Tuberculosis

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Is there any other information that I would need to know? ____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that *Palma Cicco* is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with *Palma Cicco*, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from *Palma Cicco* and/or *Osteopathic Health Centre Clinic* which will provide me with confirmation of appointments, relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Patient Signature: ____ **Date:** ____________________________