Francine Lupton, Hom, DHMS
Member of the College of Homeopaths of Ontario
Registration # 15057

Balance Health Group
1789 Queen St. East Unit 6
Toronto, ON
M4L3Y3

Adult Homeopathic Intake Form

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

(Please Print)			
Today's date:			
PATIENT INFORMATION			
Last name:	- Mr. - Mrs.	- Miss - Ms.	Marital status :
First name:	Date of birth:	Age:	Email address:
Street address:	Contact Numbers: (h) (c)		Number of children
City:	Province:		Postal Code:
Occupation:	Employer:		Work phone no.:
Referred by: (check one)	- Centre staff - Insurance plan	- Family - Hospital - Dr. - Friend	- Close to home or work - Website
Name and phone no. of Family Physician:			
Name and phone no. of previous Homeopath:			
IN CASE OF EMERGENCY			
Emergency contact person:	Home phone no.:	Work phone no.:	

VITAL STATISTICS			
HEIGHT:	**WEIGHT:**	**B.P.:**	**PULSE:**

What is your main health concern, and when did it start?

___

Was it preceded by an event, accident or mental upset? (ie. shock, worry, dietary, overexertion, weather?)

___

Does anything make it better? Worse?

___

Do you have any other health concerns? Please list in order of importance for you, and the date of onset.

___

___

___

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

- ❑Abscesses
- ❑Alcoholism
- ❑Anaemia
- ❑Appendicitis
- ❑Arthritis
- ❑Asthma
- ❑Cancer
- ❑Chicken pox
- ❑Cold sores
- ❑Depression
- ❑Diabetes
- ❑Eczema
- ❑Epilepsy
- ❑Emphysema
- ❑Gall stones
- ❑Goitre
- ❑Gonorrhoea
- ❑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
- ❑Skin disease
- ❑Strep throat
- ❑Sinusitis
- ❑Stroke
- ❑Gout
- ❑Syphilis
- ❑Tonsillitis
- ❑Tuberculosis
- ❑Venereal warts
- ❑Warts
- ❑Whooping cough
- ❑Worms

❑Others?___

Indicate your use of the following:

	Per day	Per week	Per month
Tobacco			
Alcohol			
Coffee			
Recreational Drugs			

What vaccinations have you had? List any reactions.

What exercise do you do and how much?

List any treatments, medicines, supplements, homeopathic remedies you are taking.

Treatment or Medicine	When and for how long?	Effect on you?
Any major surgeries?	When?	Complications?
Major injuries?	When?	Complications or long-term effects?

FAMILY HISTORY: Please indicate what ailments affect(ed) your family. These can include:

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

*____

Relationship	**Current Age**	**Age at Death**	**Cause of Death**	**Disease(s)**

Mother				
Maternal Grandfather				
Maternal Grandmother				
Father				
Paternal Grandfather				
Paternal Grandmother				
Sister(s)				
Brother(s)				

SYSTEMS REVIEW: Please check with a √ if you are currently suffering from, or with a P if you have suffered from any of the following disorders in the past:

Skin:
____ rashes ____ eczema ____ hives ____ acne
____ boils ____ itching ____ lumps ____ dry hair
____ dryness ____ scaling ____ moles ____ warts
____ falling/ thinning hair ____ colour changes ____ nail changes

Head:
____ headache ____ dizziness ____ vertigo ____ migraines
____ head injuries

Eyes:
____ eye pain ____ tearing ____ dryness ____ glaucoma
____ double vision ____ cataracts ____ blurring ____ itching
____ redness ____ discharge ____ impaired vision

Ears:
____ ringing ____ buzzing ____ earache ____redness
____ discharge ____ infections ____ impaired hearing

Nose/sinuses:
____ frequent colds ____ stuffiness ____ hay fever ____ nose bleeds
____ obstruction ____ loss of smell ____ nasal discharge
____ sinus problems

Mouth and throat:
____ sore throats ____ cankers ____ dry lips ____ bleeding gums
____ receding gums ____ loss of taste ____ dental cavities

Neck:
____ lumps ____ goitre ____ swollen glands

___ pain or stiffness ___ difficulty swallowing

Respiratory:
___ cough ___ sputum ___spitting blood ___ wheezing
___ asthma ___ bronchitis ___ pneumonia ___ emphysema
___ difficulty breathing ___ shortness of breath ____allergies

Cardiovascular:
___ palpitations ___ chest pain on exertion___ blueness of lips ___ swelling of ankles
___ high blood pressure ___ low blood pressure

Gastrointestinal:
___ heartburn ___ nausea ___ vomiting ___ constipation
___ diarrhea ___ gas ___ belching ___ bloating
___ abdominal pain ___ lack of appetite ___ ineffectual urging ___ haemorrhoids
___ indigestion ___ food allergies

Musculoskeletal:
___ pain in joints ___ swollen joints ___ stiffness in joints ___ broken bones
___ muscle spasms ___ cramps
___ muscle twitching

Peripheral vascular:
___ deep leg pain ___ cold hands ___ cold feet ___ varicose veins
___ ulcers ___ extremity numbness___ extremity coldness ___ extremity swelling

Neurological:
___ fainting ___ convulsions ___ paralysis ___ tremors
___ numbness ___ tingling ___weakness ___ involuntary movements
___ loss of memory ___ difficulty concentrating ___ loss of balance
___ difficulty initiating movements ___ speech problems

Endocrine:
___ cold intolerance ___excess thirst ___ excess hunger ___ sudden weight gain
___ sudden weight loss ___ heat intolerance ___ excess sweating

Reproductive system – FEMALES:
___ menstrual problems ___ sexual difficulties ___ pain/dryness during intercourse
___ problems achieving orgasm ___ difficulties conceiving or carrying a pregnancy to term
___ venereal disease Age of first menses_____ Date of last menses____________
Reproductive system – MALES:
___ testicular pain ___ testicular masses ___ abnormal penile discharges ___ sexual difficulties
___ erectile difficulties ___ fertility difficulties ___ enlarged prostate ___ venereal disease