EMPOWERING BETTER HEALTH
via the alchemy of life

HISTORY & INTAKE FORM

General Information

NAME:_____

ADDRESS:_____

_____Zip:_____

PHONE: (Home)_____

(Mobile)_____

(Work)_____

EMAIL:_____

DATE OF BIRTH: Yr:_____ Month:_____ Day:_____

Referred by: _____

MEDICAL/PROFESSIONAL WAIVER

PLEASE READ THE FOLLOWING CAREFULLY
*(*If under 18 years of age, a parent or guardian must sign)*

I, the undersigned, understand that Deb Holcomb, DSHM is a graduate from the Canadian College of Homeopathic Medicine, Toronto and is 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 D. Holcomb, I am exercising my right to choose an alternative method of treatment through which to address my total health. This represents full release and waiver of any liability on the part of Empowering Better Health, LLC, its staff or other representatives.

Client Signature:_____

Date: _____

Vaccination History / Childhood Illnesses:

Measles:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Mumps:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Rubella/German Measles:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Chicken Pox:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Whooping Cough:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Pneumonia:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

Mononucleosis:

Age Vaccinated:_____ Age when/if ill with:_____
Reaction to Vaccine? _____

ANY ADVERSE EFFECTS FROM VACCINATIONS?

Sexually Transmitted Diseases:

Type: Age:

INJURIES:

SURGERIES:

Client Information

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

_____Since:_____ Causes: _____

_____Since:_____ Causes: _____

_____Since:_____ Causes: _____

_____Since:_____ Causes: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING & FOR WHAT?

_____Since:_____ Side Effects: _____

_____Since:_____ Side Effects: _____

_____Since:_____ Side Effects: _____

WHAT TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

_____Since:_____ Results: _____

_____Since:_____ Results: _____

CIRCLE EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses, AIDS/HIV, Alcoholism, Anemia, Anxiety disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold sores, Canker sores, Colitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Gallstones, Goitre, Gonorrhea, Gout, Hay fever, Heart Disease, Hepatitis, Herpes genitalia, Influenza, Kidney disease, Leukemia, Malaria, Measles, miscarriage, Mononucleosis, Mood disorder, Mumps, Parasites (Lymes disease), Pleurisy, Pneumonia, Post-partum depression, Psoriasis, Prostatitis, Rheumatic fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-affected disorder, Sexual abuse, Skin disease, Strep throat, Sinusitis, Stroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping cough, Worms, Yellow fever
OTHER:_____

ANY OTHER MAJOR CONDITIONS:_____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN? ____

WHICH ONE (S)?_____

WHAT OPERATIONS HAVE YOU HAD:	**WHEN?**	**COMPLICATIONS?**
_____	_____	_____
_____	_____	_____

Have you lost any weight lately? How many pounds: _____

What exercise do you do and how much? _____

How much of the following substances are you using?

Tobacco:_____ Alcohol: _____ Coffee: _____ Tea:_____ Sodas:_____

Recreational drugs:_____

Are you currently under the care of another Practitioner or Medial Doctor?

Who:	**For What Condition?**	**Treatment:**
_____	_____	_____
_____	_____	_____

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

HOMEOPATH	WHEN?	FOR WHAT CONDITION?
_____	_____	_____

Can you trace the origin of any present condition to any particular circumstance (e.g., Accident, Illness, Incident, Mental Upset, Pregnancy/birth, Emotional crisis, etc.): _____

_____

ANY SERIOUS SHOCK, GREIF, DISAPPOINTMENT, DEPRESSION, ETC? _____

_____

_____

HEALTH HISTORY OF RELATIVES

Alcoholism, Allergies, Arthritis, Asthma, Cancer, Depression, Diabetes, Epilepsy, Gonorrhea, Gout, Hay fever, Heart disease, Mental illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS:

_____

	Age if alive (or) Age at & cause of death	/	**Ailments**
Mother:	_____		
Father:	_____		
Brothers:	_____		
Sisters:	_____		
Children:	_____		
Maternal Grandmother:	_____		
Maternal Grandfather:	_____		
Maternal Aunts/Uncles:	_____		
Paternal Grandmother:	_____		
Paternal Grandfather:	_____		
Paternal Aunts/Uncles:	_____		

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CASE THAT YOU WOULD LIKE TO MENTION?

_____

_____

_____

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential