Canadian College of Homeopathic Medicine

Offices & Clinic: 1881 Yonge St, Suite 500 Toronto, ON M4S 3C4 Tel. (416) 966-2350 Fax. (416) 966-1724
info@homeopathycanada.com www.homeopathycanada.com

HOMEOPATHIC CONSULTATION
(Student Clinical Externship)

General Information

NAME:_____

ADDRESS:_____

_____

_____

PHONE: (home) _____

(work) _____

E-MAIL: _____

DATE OF BIRTH: year:_____month:_____day:___

Present Age:_____

Referred by/How did you hear of our College & Clinic?:

_____

Present M.D. & phone #:_____

_____

MEDICAL/PROFESSIONAL WAIVER

PLEASE READ THE FOLLOWING CAREFULLY *if under 18 years, a parent or guardian must sign

I, the undersigned, understand that _____ is a homeopathy student at CCHM. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with _____, 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, the undersigned, do hereby acknowledge that the homeopathy student named above has explained the homeopathic assessment and recommended treatment plan. I have been given the opportunity to ask questions about the homeopathic assessment and recommended treatment plan, and received answers to those questions. I confirm that I understand the homeopathic assessment and recommended treatment plan, which included a discussion of the nature of the procedure, expected benefits of homeopathic treatment, potential risks and side effects, as well as the fee schedule for homeopathic consultations. I have also been informed of any alternative courses of action that I can take, and I understand that my consent can be withdrawn at any time during the course of homeopathic treatment. I understand that the information provided will be kept confidential and used only for the purposes of my care and educational purposes.

Patient Signature:_____

Date:_____

Appointment is Scheduled for:

DATE: _____ **TIME:**_____

Infancy:

Problems during pregnancy:

TYPE:

_____

_____

Problems during labour:

TYPE:

_____

_____

Birth Weight:

_____

Vaccination History/Childhood Illness:

Measles:

Age when Vaccinated for: Age when/if Ill with:

Reaction to Vaccine? _____

Mumps:

Age when Vaccinated for: Age when/if Ill with:

Reaction to Vaccine? _____

Rubella/German Measles:

Age when Vaccinated for: Age when/if Ill with:

Reaction to Vaccine? _____

Chicken Pox:

Age when Vaccinated for: Age when/if Ill with:

Reaction to Vaccine? _____

Whooping Cough:

Age when Vaccinated for: Age when/if Ill with:

Reaction to Vaccine? _____

Pneumonia:

Age when/if Ill:

Mononucleosis:

Age when/ if Ill:

ANY ADVERSE EFFECTS FROM VACCINATIONS?:

_____

Sexually Transmitted Diseases:

Type: Age:

_____

Injuries/Surgery:

Type: Age:

_____

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Patient Information

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

	SINCE	CAUSES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

	SINCE	ANY ADVERSE EFFECTS ON YOU
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

	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, 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, Pleurisy, Pneumonia, Post-partum depression Prostatitis, Rheumatic fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-affected disorder, Sexual abuse, Skin disease, Strep throat, Sinusitis, Stroke, Syphilis, Tonsilitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping cough, Worms, Yellow fever.

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: _____ "RECREATIONAL" DRUGS: _____

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ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN (S)?

WHO	FOR WHAT CONDITIONS?	TREATMENT
_____	_____	_____
_____	_____	_____

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

HOMEOPATH WHEN?

FOR WHAT CONDITIONS?

_____ _____ _____

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE (e.g. ACCIDENT, ILLNESS, INCIDENT, MENTAL UPSET, ETC.)

_____

ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, 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	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.