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Homeopathic Consultation Intake Form

General Information

Name: _____

Address: _____

_____

_____

_____

Phone: home _____ Work_____

Email: _____

Date of Birth: _____

Referred by: _____

Current M. D. and contact information, if applicable: _____

Date of Initial Consultation: _____

Initial Remedy Prescribed: _____Potency_____

Posology: _____

1st Follow up Date: _____

2nd Follow up Date: _____

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 Nancy Siciliana is a homeopath who 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 Nancy Siciliana, 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 medical insurance plan, I agree to pay all fees presented in the current rate schedule** for services rendered at the end of each session.

Signature:_____

Date:_____

**Current rate schedule:

Adults and children, Initial Consultation: **$300.00 plus GST**.

Follow ups**: $95.00 plus GST**.

Veterinarian: **$95 per visit/consult plus GST**.

Mileage rates apply ($ 0.50/km plus GST) for house-call consultations.

Initial consultations for adults and children are the most in-depth, and usually take about two and a half hours. Veterinary consults take about an hour.

Follow-ups are scheduled 4 to 6 weeks after the initial consultation; subsequent follow ups are scheduled as needed (usually 6 weeks – 3 months, depending on progress and dosages given). Follow-ups are usually about an hour in length.

Homeopathic remedies are prescribed one remedy at a time and may be purchased from your preferred retailer (Smiths' Pharmacy, Chopra Homeopathy, and Riverdale Homeopathics can order in virtually any remedy and potency for you as needed in the Toronto area: Nature's Source can supply you in the Niagara region, by mail delivery). Supplements may be recommended as supports to treatment only; I will specify optimum brands and suitable alternates.

Regular correspondence by phone and email in between consultations is encouraged in order to ensure the best case management. **Please call or email if you have any questions or changes to report in the times between consultations**.

Should there be any difficulty with your ability to pay, *please tell me before our consultation*. We can work out a mutually agreeable payment plan to make treatment accessible. If you are serious about restoring your health, money should not be an issue and it does not have to limit your access to treatment.

Major Complaints, In Order of Importance to You:
Complaint: Since: Suspected/Actual Cause:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medications you now take. How long have you been taking each medication?

_____

_____

Please list any other therapies/treatments undergone, duration of treatment, and any results:

_____

_____

Please circle any of the following conditions you have had:

Abscesses, alcoholism, anemia, arthritis, asthma, cancer, chicken pox, cold sores, colitis, depression, diabetes, emphysema, epilepsy, gallstones, goiter, gonorrhea, gout, hayfever, heart disease, hepatitis, herpes genitalia, influenza, kidney disease, leukemia, malaria, measles, miscarriage, mononucleosis, mumps, parasites, pleurisy, pneumonia, prostatitis, rheumatic fever, rubella, scarlet fever, sexual abuse, skin disease, strep throat, sinusitis, stroke, syphilis, tonsillitis, tuberculosis, typhoid fever, venereal warts, warts whooping cough, worms, yellow fever

Or any other major conditions?_____

Are there any of these preceding conditions after which you have never been well? If so, which ones?

_____

_____

_____

Please list any surgeries or operations you may have had in the past:

Operation When? Complications, if any:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you lost or gained any weight lately? How many pounds?

_____

_____

What kind of exercise do you do, if any?

_____

Which of the following substances do you use, if any?

(please circle)

*tobacco alcohol coffee herbal tea recreational drugs:*_____

Have you been treated with homeopathy before?

Physician:_____ When?_____

For which conditions?_____

Remedies prescribed? _____

_____

Health History of Relatives:

Please circle any of the following conditions which have presented themselves in your family's history:

Alcoholism, allergies, arthritis, asthmas, cancer, depression, diabetes, epilepsy, gonorrhea, gout, hay fever, heart disease, insanity, paralysis, pneumonia, skin disease, syphilis, tuberculosis, or…

Any other major ailments: _____

_____

_____

_____

Vaccination/Childhood Illness History (Please indicate age during which childhood illness was either experienced or vaccinated against. ***There is a routine vaccine schedule on the next page which may help remind you of when and whether you or your child have/has been vaccinated "according to schedule"***).

Measles
-age when vaccinated: _____ reaction to the vaccine: _____

or
-age when ill with the disease: _____

Mumps

-age when vaccinated: _____ reaction to the vaccine: _____

or

-age when ill with the disease: _____

Rubella/German Measles

-age when vaccinated: _____ reaction to the vaccine: _____

or

-age when ill with the disease: _____

Chicken Pox

-age when vaccinated: _____ reaction to the vaccine: _____

or

-age when ill with the disease: _____

Whooping Cough

-age when vaccinated: _____ reaction to the vaccine: _____

or

-age when ill with the disease: _____

Polio

-age when vaccinated: _____ reaction to the vaccine: _____

or

-age when ill with the disease: _____

Any adverse effects **EVER** experienced from vaccines/injections, such as symptoms like fever, flu-like symptoms, change in behaviour/mood, paralysis/numbness, change in ability to sleep/eat, strange rashes/sensitivities, symptoms resembling asthma, etc? _____

If any, please list:

_____
_____
_____
_____
_____

Family Health History Please List the following information:

	Age, if alive	Age @ death/cause	Ailments
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Child			
Child			
Child			
Child			
Maternal GM			
Maternal GF			
Maternal Aunt			
Maternal Aunt			
Maternal Uncle			
Maternal Uncle			

Uncle			
Paternal GM			
Paternal GF			
Paternal aunt			
Paternal aunt			
Paternal uncle			
Paternal uncle			
Other relative			
Other relative			
Other relative			

****

The following are questions which are meant to collect more specific information. The questionnaire is designed to collect information relevant in children's and adult cases (please answer the ones which apply in your own case; if you are a parent, please ask your child and record his/her response if possible, and also include your own observations).

CHIEF COMPLAINT:

1. What is your chief complaint? (the "CC") Tell as much about it as you can, including what bothers you about it the most. Include the sensations, the kind of pain, the location, how your energy has been affected by it. (For example, has the complaint made you restless, weak, nervous, anxious, irritable, hyper-sensitive, affected your thirst and appetite, your body temperature, and so on?).

2. When did this problem begin? What was going on in your life around that time? Do you have a

3. What aggravates the CC and what brings it on? (For example, certain types of food or weather, movement, light, noise, company, talking, heat/cold, or anything else that you can think of.) And what makes the CC better (for example, hot or cold, massage, eating, lying still, music, company...)? What do you do to try to feel better, to cope?

4. At what time of the day or night is the CC worse? Specify an hour if you can.

5. What symptoms can you identify that accompany the CC (whether directly related or not; for example, headache with nausea; or menstrual cramps with diarrhea; a cold with irritability)?

GENERAL QUESTIONS

6. Environment: With regard to the seasons, the weather, temperature, drafts, air quality, air conditioning, ocean air, mountain air, humidity, the sun, the rain/thunderstorms, cloudy weather, fog, etc., what environmental factors make you feel better or worse?

7. What position is most uncomfortable for you? Eg. Standing, sitting, lying, kneeling down, etc.

8. a) Do you tend to be chilly or warm? Are there parts of your body that are colder or warmer than the rest of you? Is there a special time of day or night when they feel colder or warmer?

b) Do you perspire a great deal? If so, when? And where on the body? (feet, head, hair, chest, armpits, etc) Does it leave a stain of a particular color? Is there a particular odor?

9. Describe what your tongue looks like (look in the mirror and describe colour/coating, shape of tongue (are there teeth indentations on the side?; are there any bumps/fissures, does the tongue have a “coating”?, etc).

MENTAL/EMOTIONAL

10. What do you worry about most? How do you deal with your worries?

11. Is your home/work environment neat or cluttered? How fussy are you about neatness and cleanliness?

12. How easily do you cry? In which situations?

13. When you are upset, what do you do to help yourself feel better? For instance, do you call your friends and tell them about it, or do you keep your emotions private, or do you put on music, or go for walk, or write an angry letter, or throw things, etc.?

14. What makes you angry? What do you do when you're angry?

15. Do you have an emotion that predominates; such as anger, depression, irritability, anxiety, jealousy, joy...or possibly two emotions that tend to alternate predictably?

16. What fears do you have? Some examples--dogs, heights, strangers, snakes, trying anything new, being approached, leaving the house, elevators, airplanes, bridges, being followed, sharp objects, insects, disease, death, germs, public speaking, rejection, and so on.

17. What have been the most difficult circumstances in your life? How did you respond to them?

18. What are the greatest joys you have had in your life?

19. What was your childhood like?

20. What bothers you most in other people? How, if at all, do you express it?

21. What causes the most problems in your relationships?

22. Do you have any recurring dreams? What are they about?

23. What would you need to feel happy?

24. What do you do at your job? Ideally, what would you like to do?

25. If you were made King or Queen for a day, what would you change?

26. When people have criticized you, what was the criticism about? Similarly, when people have praised you, what did you receive praise for?

27. What would you like to change most about yourself, what, in your opinion, is blocking your way from moving forward to where you want to be?

FOOD

28. How do you feel (physically and emotionally) before, during and after meals? How do you feel if you go without a meal?

29. What would you most like to eat (if you did not have to consider calories, fat, anything you've read about “the right way” to eat)? **Please keep in mind this is not being asked to determine whether or not your diet is sound**!! Your ***preference*** is what is important to your case.

What foods do you crave?

30. What foods do you dislike and refuse to eat?

What foods do you react badly to, and in what way?

31. How thirsty are you? What do you like to drink? Do you have a preference for how cold or hot your drinks should be?

SLEEP
32. How is your sleep?

33. Do you do anything during sleep? (for example, talk, laugh, shriek, toss about, grind your teeth, drool, snore, walk, etc.)

34. Do you have trouble falling asleep? What keeps you awake? Do you wake always at a certain time? What causes you to wake up? What position do you sleep in?

WOMEN
35. Number of pregnancies, number of children, number of miscarriages, number of abortions

36. At what age did your menses begin? (If you have gone through menopause, at what age did you do so?)

37. How frequently do they (or did they) come?

38. What about the duration, the flow--light or heavy--, the color, time of day when flow is greatest; any odour or clots? Describe clots if you have them.

39. How do you (did you) feel before, during and after menses?

HEALTH HISTORY
40. What medications are you taking at present?

41. How frequently do you get colds and flu?

42. Have you had any childhood illnesses twice, or in a very severe form, or after puberty?

43. Have you had any vaccinations? Have you ever had an adverse or unusual reaction to a vaccination?

44. Have you had any surgery? What and when?

45. Have you had at any time: warts, cysts, polyps, tumors, moles or any other skin problem? Where were they located? Were they treated with anything or removed?

46. Do you tend to have any discharges (nasal, vaginal, etc.)? What are the color, odour, and consistency?

SENSITIVITY

47. a) Do you tend to need a smaller dose of medications than most other people?

b) Do you need less anaesthesia than others, or have a hard time coming out of it?

c) Do you tend to react to vitamins and herbs and/or need hypoallergenic vitamins?

d) Are you sensitive to paint fumes, exhaust, dry cleaning fluid, fragrances etc.?

48. List, in the order of occurrence (and the age you were at the time), the events in your life that you feel you haven't fully recovered from, that have changed you in some permanent way.

49. When you have to stand in line and wait, how do you feel?

50. When a family member was last sick, what did you do?

51. What is your sexual energy level, in your opinion?

52. How do you react to consolation and sympathy?

53. What sort of things do you consider to be horrible ordeals?

54. What are your hobbies, what do you love to do?

55. Where would you go if you could go anywhere, and why?

56. Is there anything noteworthy about your face? For example, a particular set expression; acne, haggard look, droopy eyes, moles, freckles, etc.?

57. Is there anything noteworthy about your voice? For example, whining or stammering, or reflecting long before answering, or talking fast or slow, etc.

58. Who in your life is a very difficult person, and why?

Anything else you wish to add? Please add it here.

Thank you for giving this intake questionnaire the time and attention required! It is very much appreciated.