

Homeopathic Healthcare, LLC

3-Dimensional Treatment for Advanced Health, Wellness, & Vitality

The Natural Health Clinic 1707 F Street Bellingham, WA 98225 (360)734-1560 office tel.

CLINIC QUESTIONNAIRE

DATE: _____

DATE OF BIRTH: _____

NAME:	
ADDRESS:	
ZIP CODE:	
DAYTIME PHONE:	HOME:
CELL PHONE:	
Email:	

Thank you for choosing Homeopathic Healthcare, LLC!

How did you hear about us? _____



ALL INFORMATION GIVEN HERE IS KEPT STRICTLY CONFIDENTIAL

PRESENTING COMPLAINT

Please describe in detail the nature of your present complaint(s):

HOW LONG HAVE YOU HAD THIS?

DESCRIBE manner in which your complaint affects you, your lifestyle, and/or your relationships:

CURRENT TREATMENT

Current Medication – including vitamins and all other supplements: Attach separate sheet if necessary.

Other Current Therapies:



MEDICAL HISTORY

List all your major diseases, accidents, hospitalisations, treatments, traumas, and medication – in order if you can. Include childhood illnesses and any long term prescriptions such as birth control pill, blood pressure tablets, HRT, tranquilisers, etc.

<u>Age</u>	<u>Condition</u>	<u>Treatment</u>

VACCINATIONS: List all vaccinations and any severe reactions.

ALLERGIES: List all allergies, past and/or present.



FAMILY MEDICAL HISTORY

List all serious diseases/ ailments of blood relatives; age, and cause of death if applicable:
(Indicate ailments of relatives by marriage where necessary):

Please indicate where there may be a history of alcoholism, drug addiction, behavioural problems, epilepsy, Downs Syndrome, or any unusual condition or problem. This information is genuinely of value to the Homeopath and will be kept completely confidential.

Mother	Father
Grandmother	Grandmother
Grandfather	Grandfather
Aunts	Aunts
Uncles	Uncles
Cousins	Cousins
Your Brothers and Sisters	
Your Children	

