ELITAK HEALING HOMEOPATHY
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Elitak_Healing

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CHO Registration #: 15373

Homeopathic Intake Form

(CONFIDENTIAL)

Personal Information:

First Name: _____ Last Name: _____

Address:

_____

Street City Postal code

Ph. #: Home: _____ Work_____ Other_____

E-mail address: _____

Date of Birth: D_____ M_____ Y_____

Occupation: _____ Referred By: _____

Present M.D. and Phone no.: _____

Are You Currently Under the Care of a Physician(s)?

Physician	For Which Condition?	Treatments
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been treated with homeopathy before?

Homeopath	When ?	For What Conditions?

HOW DID YOU HEAR ABOUT THE PRACTICE: _____

Patient medical Information:

IN ORDER OF IMPORTANCE TO YOU:

MAJOR COMPLAINTS	SINCE	CAUSES

WHAT MEDICATIONS AND/ OR SUPPLEMENTS ARE YOU CURRENTLY TAKING?

	SINCE	ANY ADVERSE EFFECTS ON YOU

WHAT TREATMENTS OR THERAPIES ARE YOU ALSO CURRENTLY FOLLOWING?

	SINCE	RESULTS

Vaccination History/Childhood Illness:

	Age when Vaccinated for	Reaction to Vaccine?
Measles		
Mumps		
Rubella/German Measles		
Chicken Pox		
Whooping Cough		
Pneumonia		
Mononucleosis		

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 KILOGRAMS?

WHAT EXERCISE DO YOU DO AND HOW MUCH?

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO: ALCOHOL:

COFFEE: "RECREATIONAL" DRUGS:

(WOMEN) AGE OF FIRST MENSES: (WOMEN) NUMBER OF PREGNANCIES:

Pregnancies/ BIRTH: ANY COMPLICATIONS?

(WOMEN) ARE YOU PRE-MENOPUSAL? POST-MENOPOUSAL?
SIMPTOMS?

Is there any other information that I would need to know?

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism, Allergies, Arthritis, Asthma, Cancer, Depression, Diabetes, Epilepsy, Gonorrhea, Gout, Heart Disease, Insanity, Paralysis, Pneumonia, Skin Disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS: _____

_____

_____

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sister			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

PATIENT CONSENT /PROFESSIONAL WAIVER

PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.)
I, the undersigned, understand that (*Elizabeth (Erzsebet) Soos Takacs*) is a licensed homeopath and 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 *Elizabeth (Erzsebet) Soos Takacs,* a licensed homeopath, 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 (OHIP), I agree to pay all fees presented in the current rate schedule.
I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from (*Elizabeth S. Takacs*) which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Patient Signature: _____ Date: _____

Witness: _____