**Mariana Sullivan Homeopathy**

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**NEW PATIENT INTAKE FORM - ADULT**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Main Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone Number (work/ home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: (MM/DD/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender:\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Healthcare Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Homeopath if treated previously:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If currently under the care of another physician, please explain for what condition you are being treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Blood Pressure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did it start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did your illness start after an event, accident or mental upset, such as shock, worry, dietary, overexertion, weather? Please, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What makes it better or worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any other health concerns? If so, please list them in order of importance.

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List any allergies you might have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any prior conditions after which you never felt totally well again? If so, please, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE CLIENTS:**

Date of last menstrual period:\_\_\_\_\_\_\_\_\_\_\_\_

Age at First Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Miscarriages or Abortions:\_\_\_\_\_\_

Number of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please, check if you have had or are experiencing any of the following conditions:**

\_\_Abscesses

\_\_Alcoholism

\_\_Anemia

\_\_Appendicitis

\_\_Arthritis

\_\_Asthma

\_\_Cancer

\_\_Chicken Pox

\_\_Cold Sores

\_\_COVID

\_\_Depression

\_\_Diabetes

\_\_Eczema

\_\_Epilepsy

\_\_Emphysema

\_\_Gall stones

\_\_Goiter

\_\_Gonorrhea

\_\_Gout

\_\_Headaches

\_\_Heart trouble

\_\_Hypertension

\_\_Hepatitis

\_\_Herpes

\_\_Influenza

\_\_Jaundice

\_\_Kidney Disease

\_\_Leukemia

\_\_Liver Disease

\_\_Malaria

\_\_Measles

\_\_Mental Illness

\_\_Mononucleosis

\_\_Mumps

\_\_Nose Bleeds

\_\_Parasites

\_\_Pelvic Inflammatory \_\_Disease

\_\_Pneumonia

\_\_Prostate disease

\_\_Rheumatic Fever

\_\_Sexual Abuse

\_\_Skin disease

\_\_Strep Throat

\_\_Sinusitis

\_\_Stroke

\_\_Syphilis

\_\_Tonsilitis

\_\_Tuberculosis

\_\_Venereal Warts

\_\_Warts

\_\_Whooping cough

\_\_Worms

\_\_Other

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**How much of these substances do you use and how often:**

Tobacco:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List previous vaccinations and any adverse reactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What physical activity do you do? How often and how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any treatments, medicines, supplements, homeopathic remedies you are taking, for how long and their effect on you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you lost or gained any weight recently? If so, how much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any major surgeries, date and reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any major injuries, date and reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History** (what diseases affected your family, these can include:)

\_\_Alzheimers:

\_\_Alcoholism:

\_\_Asthma:

\_\_Arthritis:

\_\_Cancer:

\_\_Diabetes:

\_\_Depression:

\_\_Epilepsy:

\_\_Gonorrhea:

\_\_Hypertension:

\_\_Heart Disease:

\_\_Hepatitis:

\_\_Mental Illness:

\_\_Pneumonia:

\_\_Skin diseases:

\_\_Syphilis:

\_\_Tuberculosis:

\_\_Ulcers:

\_\_Others:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Relationships** | **Current age** | **Age of death** | **Cause of death** | **Disease(s)** |
| --- | --- | --- | --- | --- |
| Mother |  |  |  |  |
| Maternal Grandmother |  |  |  |  |
| Maternal Grandfather |  |  |  |  |
| Father |  |  |  |  |
| Paternal Grandmother |  |  |  |  |
| Paternal Grandfather |  |  |  |  |
| Sister(s) |  |  |  |  |
| Brother(s) |  |  |  |  |
| Aunt(s) |  |  |  |  |
| Uncle(s) |  |  |  |  |
| Children |  |  |  |  |