# Heinrichs Homeopathy

Gentle Medicine • Genuine Health

Lisa Heinrichs, Homeopathic Consultant
Cell: 403.392.1128
E-Mail: lisa@heinrichshomeopathy.ca
Website: heinrichshomeopathy.ca


## Client Information (please print)

Name: Date:

Telephone (best number to reach you) :

Email:

Age: Date of birth: Gender:

Address:

Occupation:

Spouse/Partner's Name:

Parent's Names ( if client is a child ):

Children's Names & Ages **even if adults** (Sibling names if client is a child):

*NAME:* *AGE:*

_____ _____

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### Medications presently taking and what they are for.

List all prescription and non-prescription medications you are currently taking and what they are for.

List all vitamins/minerals/herbal supplements you are currently taking and what they are for:

## Health Concerns

1. What are your chief complaints? Please **briefly** list the ailment(s).

2. When did you first have this/these complaint(s), even in a very mild form?

3. What, if any, diagnosis was made? What diagnostic tests were performed?

4. Did you consult with a health professional? If so, what is their specialty?

Please list any known history of disease in your family such as cancer, heart disease, diabetes, alcoholism, etc. What is your relationship? If deceased, what was your parents', grandparents', siblings' cause of death?

Please list any treatments and/or noteworthy medical events. Specific dates don't matter; approximate as best you can.

| **Date**<br>(Present to past) | **Medications/Treatments/Noteworthy medical events**<br>*please include dental history such as any extractions/root canals/wisdom teeth removal |
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Signature

Date