Alt Therapies Center
HOMEOPATHY | ACUPUNCTURE | CHINESE MEDICINE

Case History Information

Name: _____ Birthdate: _____ Age:_____

Address: _____

City: _____ Occupation: _____

State: _____ Zip: _____ Employer: _____

Phone (work): _____ Employment Adress: _____

Phone (cell): _____ City: _____ State: _____

Email: _____

Your Doctor's Name:_____

Your Doctor's Phone:_____ Referred by: _____

Diagnosis by your Doctor: _____

Present Complaints:_____

_____

CONSENT FOR HOMEOPATHIC TREATMENT AND CARE

I, the undersigned do hereby request and consent for the homeopathic treatment. I have been informed that homeopathic remedies are safe, but occasionally there may be aggravation of the symptoms just for few hours.

I wish to rely on the homeopathic practitioner to exercise judgment during the course of the treatment, which the practitioner feels at the time, is in my best interests.

By signing below, I agree to the above named therapy. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature: _____ Date: _____

Alt Therapies Center
Sucheta Dagli Shah LAC, MSOM

Case History Information

Name: _____ **Date:** _____

*Be brief in your answers below. A check '✓' **'yes'** **'no'** or **one** to **two** words is enough.*
Dr. Shah will go into greater detail with you during the interview.

Please List Current Medications:

_____

_____

_____

_____

_____

_____

Family Diseases:

Mother:

_____

Father:

_____

Mother's Mother:

_____

Mother's Father:

_____

Father's Mother:

_____

Father's Father:

_____

Surgeries: (What Year & Kind?)

_____

_____

_____

_____

Trauma: (✓ if you have had)

_____ Motor Vehicle Accident
_____ Loss of Consciousness
_____ Bums
_____ Fractures
_____ Head Injury
_____ Sprains (recurrent)
_____ Heat / Sun Stroke

Cardiovascular: (✓ if you have had)

_____ Blood Pressure (High)
_____ Heart Problems
_____ Clots / Phlebitis
_____ Varicose Veins
_____ Anemia

Lungs: (✓ if you have had)

_____ Shortness of Breath
_____ Asthma
_____ Bronchitis
_____ Pneumonia
_____ Other Lung Problem(s)

Hormonal Problems:
(✓ if you have had)

_____ Diabetes Mellitus
_____ Thyroid Problems
_____ Other

Infectious Diseases / Parasites
(✓ if you have had)

_____ Infections
(Ear, Nose, Throat, or Sinus Infections)
Are They Recurrent? ☐ Yes ☐ No

_____ Malaria
_____ Mononucleosis
_____ AIDS / HIV
_____ Tuberculosis
_____ Lyme Disease
_____ Worms (parasites)
_____ Other

Joint or Muscle Problems?
☐ Yes ☐ No

Urinary Problems:
(✓ if you have had)

_____ Bladder or Kidney Infections
Are They Recurrent? ☐ Yes ☐ No

_____ Kidney Stones

Liver:
(✓ if you have had)

_____ Hepatitis
_____ Gallbladder Stones

Allergies:
(✓ if you have had)

_____ Airborn (pollens. etc.)
_____ Food(s)

Skin:

Name of Condition _____

Cancer: (Year & Diagnosis Type)

Year: _____

Diagnosis Type: _____

Substance Abuse:

_____ Alcohol
_____ Marijuana
_____ Cocaine
_____ Other (Please List)

_____

_____

Venereal Diseases:
(Please List)

_____

_____

_____

Exposure to Chemicals / Toxins
(Please List)

_____

_____

_____

Bad Reaction to Any Drug or Vaccination?
☐ Yes ☐ No

If yes, what?

_____

_____

_____

Warts Now or Ever?
☐ Yes ☐ No

Headaches or Migraines?
☐ Yes ☐ No

Vertigo or Dizziness?
☐ Yes ☐ No

Memory of Concentration Issues?
☐ Yes ☐ No

Jerking or Trembling?
☐ Yes ☐ No

Numbness or Tingling?
☐ Yes ☐ No

Sleep Problem?
☐ Yes ☐ No

Dental Problems?
☐ Yes ☐ No

Mental or Emotional Issues:
(Please List)

_____

_____

_____

Female Patient Questionnaire

Name: _____ **Date:** _____

Date of Birth: _____ **Referred By:** _____

Date Of Your First Menstruation. _____

Are You Now, Or Have You Ever Uses Birth Control Pills? ☐ Yes ☐ No

Do You Have PMS? ☐ Yes ☐ No

Do You Have Difficult Periods? ☐ Yes ☐ No

Do You Have Clots? ☐ Yes ☐ No

Any Vaginal Discharges Now, Or In The Past? ☐ Yes ☐ No

Do You Have, Or Have You Had Lumps In The Breasts? ☐ Yes ☐ No

How Many Pregnancies? _____

How Many Live Births? _____

How Many Cesarian Section (C-Section) Births? _____

Have You Had Any Miscarriages? _____

Have You Had Any Abortions? _____

Are You In Menopause? ☐ Yes ☐ No

If Yes, When Did It Start? _____

Do You Have Any Hot Flashes? ☐ Yes ☐ No

Have You Ever Had Any Cysts On The Ovaries? ☐ Yes ☐ No

Any History Of Fibroids On The Uterus? ☐ Yes ☐ No

Have You Had A Hysterectomy? ☐ Yes ☐ No

Any History Of Endometriosis? ☐ Yes ☐ No

Any History Of Rape? ☐ Yes ☐ No