

## Case History Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Employment Address: \_\_\_\_\_

Phone (cell ): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

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

Your Doctor's Name: \_\_\_\_\_

Your Doctor's Phone: \_\_\_\_\_ Referred by: \_\_\_\_\_

Diagnosis by your Doctor: \_\_\_\_\_

Present Complaints: \_\_\_\_\_

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### 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: \_\_\_\_\_

# 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:

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## Family Diseases:

Mother:

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Father:

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Mother's Mother:

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Mother's Father:

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Father's Mother:

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Father's Father:

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## Surgeries: (What Year & Kind?)

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## Trauma: (✓ if you have had)

- \_\_\_\_\_ Motor Vehicle Accident
- \_\_\_\_\_ Loss of Consciousness
- \_\_\_\_\_ Burns
- \_\_\_\_\_ 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)

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## Venereal Diseases:

(Please List)

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## Exposure to Chemicals / Toxins

(Please List)

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## Bad Reaction to Any Drug or Vaccination?

Yes  No

If yes, what?

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## 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)

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