

CLIENT REGISTRATION/INTAKE

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CLASSICAL HOMEOPATHY

Today's Date _____

Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Phone (Day) _____ (Evening) _____

Cell Phone _____ Email _____

Occupation _____ Employer _____

Emergency contact: _____

Other Household Members/Relationship:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Referred By: _____

SYSTEMS REVIEW

(Place an "N" next to any item that applies to you NOW and a "P" next to any item that you had in the PAST)

SKIN

- ___ Hives/rash
- ___ Eczema
- ___ Psoriasis
- ___ Herpes
- ___ Acne
- ___ Warts/keleoids/moles
- ___ Bruise easily
- ___ Other? _____

HEAD

- ___ Epilepsy/Seizures
- ___ Headaches/Migraines
- ___ Dizziness/Vertigo
- ___ Injuries/concussions
- ___ Dandruff/Seborrhea
- ___ Other? _____

EYES

- ___ Dry/irritated/tearing
- ___ Visual Disturbances
- ___ Glaucoma
- ___ Cataracts
- ___ Other? _____

EARS

- ___ Impaired hearing
- ___ Ringing, buzzing, etc.
- ___ Frequent Infections
- ___ Discharge
- ___ Other? _____

NOSE

- ___ Frequent nosebleeds
- ___ Sneezing/runny nose
- ___ Sinus trouble
- ___ Chronic colds
- ___ Hay fever/allergies
- ___ Odor sensitivity
- ___ Other? _____

MOUTH/THROAT

- ___ Halitosis
- ___ Bleeding gums
- ___ Tooth decay
- ___ Metallic/other taste
- ___ Tongue problem
- ___ Sore throat/tonsillitis
- ___ Swollen glands
- ___ Other? _____

RESPIRATORY

- ___ Asthma/wheezing
- ___ Shortness of breath
- ___ Pneumonia/pleurisy
- ___ Lung disease
- ___ Chronic cough
- ___ Cough with blood
- ___ Other? _____

CARDIOVASULAR

- ___ Chest pain/pressure/tightness
- ___ Difficulty walking, exercising
- ___ Palpitations
- ___ Swelling of hands/feet
- ___ Heart murmur/disease
- ___ Hypertension
- ___ Varicose veins
- ___ Other? _____

GASTROINTESTINAL

- ___ Heartburn/indigestion
- ___ Cramping/gas
- ___ Nausea/vomiting
- ___ IBS/colitis
- ___ Ulcers
- ___ Diarrhea
- ___ Constipation
- ___ Black stools
- ___ Hemorrhoids
- ___ Hepatitis/Jaundice
- ___ Gallbladder disease
- ___ Change in appetite
- ___ Change in bowels
- ___ Other? _____

ENDOCRINE

- ___ Diabetes
- ___ Thyroid disorder
- ___ Hormonal problems
- ___ Change in hair growth
- ___ Excessive sweating
- ___ Unusual coldness/heat
- ___ Other? _____

SENSITIVITIES

Are you a warm or chilly person? _____

What weather affects you and how? _____

How is your appetite? _____

What foods have an effect on you, what do you crave?

Are you thirsty/not thirsty? _____

Prefer hot, warm, cold drinks? _____

Please explain any sensitivities to:

Odors _____

Sun _____

Moon phases _____

Environment _____

Noise _____

Music _____

Crowds _____

Closed spaces _____

Disorder/clutter _____

Other _____

How are you affected by:

Physical exertion _____

Mental exertion _____

Touch _____

Consolation _____

Being alone _____

Animals (be specific) _____

Please explain any particular fears, now or in the past: _____

Recurrent dreams, now or in the past _____

Please use a separate sheet if necessary if there's anything further you'd like to add:

FAMILY HISTORY

Please fill in the details of your family's medical history best as you can.

	Age	History of illness, current state of health	Age of death	Cause of death
Father				
Mother				
Brothers				
Sisters				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

Additional information about any diseases that occur frequently in your family:
