Finlandia
PHARMACY & NATURAL HEALTH CENTRE

Retail Store & Pharmacy:
1111 West Broadway
Vancouver, B.C., V6H 1G1
(604) 733 - 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, B.C. V6H 2P6
(604) 734 - 7760

Homeopathy Intake Form

Note to Patient: Determining the proper remedy involves investigating and evaluating all of the subjective and objective symptoms that you are experiencing in the context of your individual life, circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation the most effective, I request that you complete the following information form as in-depth and accurately as possible. All information is kept in strict confidence. If you have any questions please do not hesitate to contact me. Please use the back of the page if more space for answers is needed.

Full Name: _____
Address: _____
City Province: _____
Postal Code: _____
Phone #: _____
Other #: _____
Email: _____
Birthday (M/D/Y): _____
Sex: _____
Height: _____
Weight: _____

Hair colour: _____
Eye colour: _____
Marital Status: _____
Occupation: _____
Family Doctor (FD): _____
FD Phone Number: _____
FD Fax: _____
FD Email: _____
FD Adress: _____
FD City / Province: _____

Medical Complaints /Reasons you are seeking Homeopathic Treatment (please list in order of importance to you):

1.

2.

3.

4.

5.

6.

Medical History:

Immunizations (please circle all those you have had):

Diphtheria

Tetanus

Polio

Whooping Cough

Other (please specify):

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Have you had any adverse reactions to vaccinations? If yes, please explain:

Do you have allergies? If yes, please list along with any medications you may be taking:

Have you or do you currently suffer from:

Alcoholism:	Y / N	High / Low Blood Pressure:	Y / N
Abortion:	Y / N	Miscarriage:	Y / N
Depression:	Y / N	PMS:	Y / N
Drug abuse:	Y / N	Sexual Abuse:	Y / N

Do you use the following (please circle all that apply):

Alcohol:	Y / N	Laxatives:	Y / N
Antacids:	Y / N	Margarine:	Y / N
Carbonated drinks:	Y / N	Non-sugar sweeteners:	Y / N
Coffee:	Y / N	Salt:	Y / N
Dairy Products:	Y / N	Sweets:	Y / N
Distilled water:	Y / N	Tea:	Y / N
Fast foods:	Y / N	Tobacco:	Y / N
Fried Foods:	Y / N	Wheat products:	Y / N

Please list any pharmaceutical drugs and/or nutritional supplements you are taking (vitamins, herbs, etc.) Use back of page for longer lists:

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What medications have you taken in the last year?

What surgeries have you had during the course of your life?

What major injuries have you had during the course of your life?:

Have you suffered from the following conditions? (Please circle all that apply)

Abscesses	Influenza	Rubella
Anemia	Kidney Disease	Scarlet Fever
Arthritis	Leukemia	Skin Diseases
Asthma	Lyme Disease	STDs
Cancer	Malaria	Sinusitis
Chicken Pox	Measles	Strep Throat
Cold Sores	Mononucleosis	Stroke
Diabetes	Multiple Sclerosis	Sunstroke
Eczema	Mumps	Tonsillitis
Emphysema	Parasites	Tuberculosis
Epilepsy	Pelvic Inflammatory Disease	Typhoid Fever
Frequent Colds	Peritonitis	Venereal Warts
Gallstones	Pleurisy	Warts
Gout	Pneumonia	Whooping Cough
Heart Disease	Prostatitis	Worms
Hepatitis	Psoriasis	Yellow Fever
HIV	Rheumatic Fever	

Other conditions not listed here:

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Has there been any grief, shock or traumas that have affected you in the past or present?

Have you ever been treated homeopathically before? If yes, please list for what conditions and if they were helpful.

Family Medical History:

Family Member	Conditions	Age (current or at time of death)
Mother		
Father		
Sister (s)		
Brother (s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Parternal Grandmother		
Aunts, Uncles		

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Tips on observing your symptoms and reporting them for Homeopathic Purposes (if it helps, write/outline on the back of the page) These are the kinds of questions you will be asked in the initial consultation:

1. Describe in detail, the onset of your symptoms. Outline any related mental, emotional or physical symptoms and/or any external conditions that may have contributed to your state of being at that time.
2. Outline all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these ailments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?
3. Describe any symptom you are experiencing in terms of its location in the body. Does this symptom shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptoms? How does it feel/look/smell/taste? Anything that makes the symptom unique, striking or unusual? If pain is involved, describe the pain you endure such as a dull ache vs. a stabbing pain, a constant or periodic pain, etc. Describe the onset of your pain; slow vs. sudden? How intense is the pain (on a scale of 1 to 10 - 10 being the most painful)?
4. Write down when your symptoms feel better or worse: time of day/ when hot or cold/ month/ season/ before or after eating / sleep/ moving / resting/ certain positions / when occupied / specific mental or emotional states.
5. Are you affected in any way by different kinds of weather? Dryness / humidity/ approaching storms/thunderstorms / frost/ cloudiness / low or high altitudes / being by the sea shore.
6. Urination (if of concern): color / odor / sediment / quantity / frequency / urgency.
7. Stool (if of concern): color/ odor/ sediment / quantity/ frequency / urgency.
8. Menses: length of cycle / length of period / significant pain associated with menses / nature of the flow / clotting / cramping / PMS / mood swings / bloating / swollen tender breasts / cravings / vaginal discharge with or without menses.
9. Sex: Desires / aversion / painful intercourse / vaginal dryness / impotency.
10. Perspiration: profuse / scanty / odor.
11. Body Temperature: Hot vs. Cold body type / hot or cold hands or feet / hot flashes.
12. Sleep: do you wake up at night? What time? How do you feel in the morning on rising? What position do you sleep in the most? Are parts of the body covered or exposed when sleeping? What kinds of dreams do you have? Any recurring dreams or nightmares? Do you have trouble falling asleep?
13. What motivates you in life? Are there lasting traits from childhood that are still an issue today? Are there running themes in your life? Eg "All my life I've been..." How would others describe you? How do you deal with change in your life? Do you need structure in your life?

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I, _____ , the undersigned understand that Kathryn Final is not a medical doctor, but instead a **Registered Homeopath**. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Kathryn Final, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future conditions. I also reserve the right to terminate homeopathic treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its totality.

As homeopathy is not covered by existing government medical insurance plans, I agree to pay all fees incurred (rates are subject to change).

Some extended health care plans now cover Homeopathy

Please Note:
- All fees are payable at the end of each consultation
- Fees do not include tax or remedies

Patient's Signature: _____ Date: _____
(If under 18 years of age, a parent or guardian must sign on your behalf)

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Informed Consent

Statement of Acknowledgement

As a patient of this Health Centre I have read the information and understand that the form of medical care is based on alternative and other supportative principles and practices. As Finlandia is an integrated health centre, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

_____ _____

Signature Date