Blackmore Wellness
HOMEOPATHY

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Consultation Form

Patient Information			For Office Use Only				
Name:				**Name**	**Potency**	**Dose**	**Date**
Address:			**Initial Rx**				
Phone:			**1st Follow Up Rx**				
Email Address:							
Date of Birth YYYY/MM/DD			**2nd Follow Up Rx**				
Referred by:							
Current M.D. (name/phone)			**3rd Follow Up Rx**				

Major Complaints in Order of Importance For You:

Complaint	Since	Causes

Which Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments Are You Currently Following?

Treatment	Since	Results

Which Of The Following Conditions Have You Ever Had? (Please circle)

Abscesses	AIDS/HIV	Alcoholism	Allergies	Amnesia	Anemia	Asthma
Cancer	Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Emphysema
Epilepsy	Gall Stones	Goitre	Gonorrhea	Gout	Hay Fever	Heart Disease
Hepatitis	Herpes Genitalia	Influenza	Kidney Disease	Leukemia	Malaria	Measles
Miscarriage	Mononucleosis	Mumps	Parasites	Pelvic Inflammatory Disease		Peritonitis
Pleurisy	Pneumonia	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sun Stroke	Syphilis	Tonsillitis
Tuberculosis	Typhoid Fever	Venereal Warts	Warts	Whooping Cough	Worms	Yellow Fever

Any Other Major Conditions Not Listed?_____

Are there any of the preceding conditions after which you have not been totally well again? Please identify which ones.

_____

Age of first Menses: _____ **Number of Pregnancies**: _____

Are You Currently Under the Care of a Physician(s)?

Physician	**For What Condition?**	**Treatments**
_____	_____	_____
_____	_____	_____

What Major Operations Have You Had?

Operation	Month/Year	Complications

What Major Injuries Have You Had?

Injury	Month/Year	Complications

Vaccination History/Childhood Illness: (Please circle)

Measles	Yes	No	**Any Adverse Effects from any of these Vaccinations?**
Mumps	Yes	No	_____
Rubella/German Measles	Yes	No	
Chicken Pox	Yes	No	_____
Whooping Cough	Yes	No	

How Much of the Following Substances Do You Use?

Tobacco_____Alcohol_____Coffee_____Recreational Drugs_____

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Insanity	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis				

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Is there any other information that I would need to know?

_____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Mary Blackmore is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Mary Blackmore, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Patient Signature:_____ **Date:**_____

Witness Signature: _____