Registration Form (Confidential)

Fill out, print and bring to consultation.

For Skype consultations, fill out, copy/paste on Word or Pages document and email to ingrid@homeopathe.ca

Name:

If under 18,
Parents names:

Age: Date of birth:

Adress:

Postal code (Zip):

Tel. Home: Cell Phone

Email:

I wish to be part of your mailing list and receive health information and homeopathy tips : ☐

Recommended by:

Health conditions in your order of importance

	Problem	Since	Causes
1.			
2.			
3.			
4.			

What medication are you presently taking?

	Medication	Since	Side Effects?
1.			
2.			
3.			

What treatment or Diet are you presently following?

	Treatment or Diet	Since	Results
1.			
2.			
3.			

Indicate the year and month if possible, of all illnesses and health troubles you have had in your life. Please write year, if possible.

Abscess		Epilepsy		Kidney Disorder		Sinusitis	
Alcoholism		Miscarriage		Malaria		Syphilis	
Allergies		Yellow fever		Menopause		Typhoid	
Skin Condition		Goiter		Mononucleosis		Tuberculosis	
Anemia		Gonorrhea		Mumps		Urethritis	
Arthritis		Gout		Otitis		Vaginitis	
Asthma		Influenza		Parasites		Small Pox	
Bulimia		Hepatitis		Pleuresy		Worms	
Gallstone		Herpes		Pneumonia		Warts	
Condylomata		Genital Herpes		Prostatitis		Genital Warts	
Cough		Stroke\Angina		Articular. Rheumatism		Zona	
Depression		Throat infection		Hay Fever		Bronchitis	
Diabetes		Leukemia		Measles		Cancer	
Emphysema		Heart Disease		Rubella		Tonsilitis	
Endometriosis		Skin Disease		Scarlet fever			

Other major illnesses or any you never got over ?

	Which operations did you have ?	When?	Complications?
1.			
2.			

Major injuries?	When?	Long term effects?
1.		
2.		
3.		

List all vaccines received	When?	Side effects?
1.		
2.		
3.		

Have you taken antibiotics repetitively or for a long period?

yes ○ No ○

If yes, When ?	What was the cause?

Any important weight loss or gain?

yes ○ No ○

How much ?

Which exercises do you do?

Exercises:	Frequency:
1.	
2.	
3.	

How much of the following substances do you use? Specify per day or week.

Tobacco/Alcohol:		Coffe:	
Tea:		Drugs:	

Indicate number of:

Pregnancies:		Children:	
Abortions:			

Indicate which of the following affected your relatives:

Alcoholism ☐	Depression ☐	Heart Disease ☐	Syphilis ☐
Allergies ☐	Diabetes ☐	Skin Disease ☐	Mental Problems ☐
Arthritis ☐	Epilepsy ☐	Paralysis ☐	Tuberculosis ☐
Asthma ☐	Gonorrhea ☐	Pneumonia ☐	
Cancer ☐	Gout ☐	Hay Fever ☐	

About Your Family:

	Age if living	Age of Death	Major Illnesses
Mother:			
Father:			
Sisters:			
Brothers:			
Children:			
Maternal Gd-mother:			
Maternal Gd-father:			
Maternal Uncles\Aunts:			
Paternal Gd-mother:			
Paternal Gd-father:			
Paternal Uncles\Aunts:			

When was your last complete medical examination?

Are you presently under the care of another doctor or therapist?

	Doctor name?	For which illnesses?	Treatments and Results?
1.			
2.			

Have you ever received a homeopathic treatment?

	Homeopath name?	For which illnesses?	Treatments and Results?
1.			
2.			

Registration Form Part 2

About yourself

Should you type the answers, please use a different colour or font so the answers may be easily distinguished from the questions. Thank you

How long have you suffered from your symptoms?
(For each health condition, when did they appear, what year, month, time of the year?)

How did your symptoms appear?
(In what circumstances, in what way, which side of your body? Give all details you can remember)

Do you notice any particular state of body or mind that appears together with your symptoms? Any change of mood?

Any other detail you wish to share about your symptoms?

FOOD

What are your food cravings, the food you could not go without? ***(including spices, salt, ketchup, sugar, healthy or unhealthy , what are your STRONG taste preferences, if any ?)***

What are our food aversions? Things you can not bear the taste or smell of ?

Any food allergies or intolerances ? Any food or condiments that do not agree with you? (They may cause a stomachache or headache, fatigue...)

How is your appetite? (Hour of the day, of the night. Rythms)

Any preference for food temperature?

How is your thirst ? (Day, night. Craving or aversions for beverages?)

Any preference for temperature ?

DIGESTION

How is your digestion?

How is your bowel movement? (any recurring particularity or concern about your stool? Too hard, painful, fissures and bleeding, too soft, frequent soft stool or diarrhea ? Any discomfort when passing stool?)

Urination? (frequency, any particularity?)

MENSTRUAL CYCLE

When did you get your first menstruation? How is/was your cycle? Any PMS? Any pain?

CLIMATE

What are your significant reactions to different climates, seasons, sun, wind, rain, dampness, dryness, thunderstorm ? Comfort, discomfort?

BODY TEMPERATURE

Are you chilly, hot, do you perspire too easily and profusely ? If so, on which part of your body ? Anything significant and recurring ? If so, what time of the day or night? Comfort, discomfort?

SLEEP & DREAMS

Anyting recurring or significant about your sleep?
(Including sleep walking or talking, state of mind at night before falling asleep, any ritual to fall asleep, favoutite position, waking up in the middle of the night?)

Do you easily fall asleep ?
What is your state of mind upon going to sleep?

How is the quality of your sleep ?

Do you wake up regularly at night ? If so, under specific stress or circumstances?

Refreshed or not in the morning?

Anything else around your sleep that is significant to you?

What are your recurring dreams? (Present or past)
If not recurring, please write dreams that you remember and period of life, if possible.

EMOTIONS

What makes you happiest ? (thrilled, excited)

What are your present recurring fears?

As a child,what were your recurring fears?

Any significantly reccuring emotions? Under what kind of circumstances? (anger, sadness, frustration, embarassement, disappointment, humiliation, excitement, disappointment, aprehension, anticipation... or else ?)

What makes you very sad, upset ? (Please give an example)

What makes you cry? (In your life, or outside your life, things you've been through or things you have seen outside your own life that made you cry ?)

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IMPORTANT. PLEASE NOTE

Once your appointement if booked, I need a notice of at least 24 hours for cancellation so your time may be offered to someone else who may need it. Without this 24 hour notice, your appointement will be charged. Paypal payments are nun-refundable if you do not show up for the consultation. Nevertheless, I remain flexible for emergencies.

Please sign here that you have read and accpeted these conditions.

SIGNATURE_____

IMPORTANT NOTICE : During your homeopathic treatment, it is important to avoid any contact (food, tea, lotion, essential oils, chewing gum, toothpaste...) with pepper mint, menthol, camphor and eucalyptus. They can antidote the remedy and stop its healing effect.