GUIA VITA HOMEOPATHIC CLINIC

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ACUTE HOMEOPATHIC INTAKE FORM

Date:		**Referred by:**		
Name:				
Address:				
City:		**Province:**	**Postal Code:**	
Home Phone:		**Cell Phone:**	**Work Phone:**	
Email address:				
Marital Status:	**Single:**	**Married:**	**Divorced:**	**Widowed:**
Date of Birth:		**Age:**	**Sex: F____ M_____**	
Height:		**Weight:**		
Emergency Contact Person: **Telephone No.:**			**Relationship:**	

Chief Complaint: Please state the condition and when it started.

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What medications / supplements are you taking for this problem?

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____

What makes it feel better?

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____

What makes it feel bad?

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____

SENSATION/FEELING:

Describe the sensation you feel. How does it feel like being in this condition?

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What is the intensity of your condition? (Please circle)

0------1------2------3------4------5------6------7------8-----9-----10

Very Mild Moderate Extremely intense

TIME:

How frequently do you experience the effects of this problem? (Please circle one or more)

a) **Constantly b)Hourly c) Daily d) Nightly**
e) Other: ____

MODALITIES: Please indicate **amel.** for **ameliorate** and **agg.** for **aggravate**

TEMPERATURE		ENVIRONMENT		MOTIONS		BODY FUNCTIONS	
HEAT-Heat in general		Damp		Commencing in motion		Eating	
Heat under the sun		Humid		Continued motions		Drinking	
Warmth of a bed		Weather changes		Exertion		Urinating	
Warm rooms		Windy		Rising up		Defecating	
Application of heat		Overcast / Stormy		Resting		Sleeping	
COLD-Cold in general		At an altitude		Stretching		Coughing	
Cold air / draft		Indoors		Lifting		Yawning	
Cold water		Outdoors		POSITION		Sneezing	
Cold application		By the sea		Lying		Sexual activity	
		SENSORY		Standing		PSYCHOLOGICAL	
		Touch		Sitting		Excitement	
		Pressure		Stooping		Effects of Anger	
		Noise		Stretched out		Fear of Shock	
		Music		Doubled up		Stress	
		Light		Right side		Worry	
		Darkness		Left side		Thinking about it	
		Odors		Stiff		While busy	
				Limp			