LAKESIDE HOMEOPATHY

17 Richmond Park Drive, Keswick, ON L4P 0H2

Eva Sidoti, Hom DSHM (Classical Homeopath)

CONFIDENTIAL NEW PATIENT INFORMATION

This form assists me in giving you a thorough evaluation and helps me to work with you to create a healing plan. Please share as much as you are comfortable with.

Name _____ Date _____

Address _____

Phone #

Home _____ Work _____ Cell _____

Best time and phone number for you to be contacted at _____

Email Address _____ Occupation _____

Referred by _____

Have you previously seen a Homeopath? Yes No

What homeopathic remedies have you taken before?

_____

Birth Date Day _____ Month _____ Year _____ Age _____ years old

What is your gender identity?

_____

Status

Single Common-Law Married Separated Divorced Widowed

Name of Spouse _____

Children _____

Names/Ages of Children_____

Emergency contact name _____

Relationship _____ Phone # Home _____ Work _____

Primary care physician name _____ Phone # _____

Address _____

Please check off other services you are currently receiving

Naturopathic Massage Therapy Chinese Medicine Physiotherapy Chiropractic Other (please describe) _____

If necessary, do you give permission to consult with your other healthcare providers? Yes No

What are your primary health concerns in order of importance to you?

Complaint	Since	Cause

Have you been given a diagnosis?

_____

_____

To what extent does this problem affect your daily life? (work, sleep, eating, relationships, your feelings about yourself, etc.)

_____

_____

_____

_____

TREATMENTS - Please list any treatments currently or previously used for this condition and their results.

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Treatment	Since	Results

Other Concerns:

_____

_____

_____

_____

Past Medical History

Please list previous medical procedures, surgeries, hospitalizations and major traumas (including auto accidents, falls, etc.).

Please list the medications and/or supplements that you are currently taking with dosages. Include current prescriptions, non-prescription medications (e.g., aspirin, Tylenol, Ibuprofen) and/or health supplements (e.g. vitamins, minerals, herbs).

Approximate date/year	Surgery/hospitalizations/procedures/injuries

MEDICATIONS / SUPPLEMENTS

Name (Of medication or supplement)	Dose (Milligrams, grams or # of capsules, tablets, teaspoons,)	Frequency (Per day/ week/ month)	Duration (How long have you been taking this?)

What Vaccines have you had:_____

Any adverse effects from them:_____

Age of first menses:_____

Issues in Pregnancies or Births:_____
_____
_____
_____

Family Medical History - Please list any significant diseases prevalent in your family.

Family Member	Age	General Health	Specific Diseases
Mother			
Father			
Sibling 1			
Sibling 2			

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Sibling 3			
Sibling 4			
Grandparent 1			
Grandparent 2			
Grandparent 3			
Grandparent 4			

General Review

Height _____ Weight _____ Maximum weight _____ When? _____

Does your weight tends to fluctuate or remain the same?

_____

Has there ever been a time in your life when your weight has dramatically increased or decreased? Please explain.

_____

_____

Best time of day for energy? _____

Worst time of day for energy? _____

How many hours of sleep do you get on average each night?_____

What do you do for exercise?

_____

_____

What do you do for enjoyment?

_____

_____

_____

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List your stress factors (physical, chemical, psychological)

Work:_____
_____
_____

Home:_____
_____
_____

Average energy level during the day (0 = none, 10 = max) 0 1 2 3 4 5 6 7 8 9 10

Please circle any conditions you currently or previously have had:

Abscesses, Anemia, Arthritis, Asthma, Alcoholism, Cancer, Chicken Pox, Cold Sores, Diabetes, Eczema, Emphysema, Epilepsy, Frequent Colds, Gallstones, Genital Herpes, Gonorrhea, Gout, Heart Disease, Hepatitis, HIV, Influenza, Kidney Disease, Leukemia, Lyme Disease, Malaria, Measles, Mononucleosis, Mumps, Parasites, Pelvic Inflammatory Disease, Peritonitis, Pleurisy, Pneumonia, Prostatitis, Psoriasis, Rheumatic Fever, Rubella, Scarlet Fever, Sexual Abuse, Skin Diseases, Sinusitis, Strep Throat, Stroke, Thyriod, Sunstroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid Fever, Venereal Warts, Warts, Whooping Cough, Worms, Yellow Fever, Other:
_____

Please circle any conditions that apply to you:

Change in appetite, Changes in thirst, Changes in weight, Changes in sleep, Changes in thermals (hot / cold), Changes in mood, Changes in behaviour, Changes in thought, Other:
_____

Please describe your average daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please list any known food allergies/intolerances and environmental allergies/sensitivities
_____
_____
_____

How many cups of each do you drink?

coffee ___/d tea ___/d cola ___/d alcohol ___/w Do you smoke? Yes No Occasionally

Are you exposed to smoke? Yes No

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Do you use recreational drugs? Yes No Occasionally (List)

Do you drink alcohol? Yes No Occasionally

Personal Review

What things in life bring you the most joy?

_____
_____
_____

What situations in life cause you the most difficulty?

_____
_____
_____

If you could change anything about your life, what would it be?

_____
_____
_____
_____

What are your health goals for the next five years?

_____
_____
_____
_____

What are your personal goals for the next five years?

_____
_____
_____
_____

What are your hopes for homeopathic treatment? Why did you choose homeopathy?

_____
_____
_____
_____

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Is there anything else you would like to share?

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form and for choosing to work with me.

FEE SCHEDULE: (Payment Options: E-transfer, Cheque, Cash)
INITIAL VISIT $160 PEDIATRIC $125 FOLLOW-UP $65 EXTENDED FOLLOW UP $80
ACUTE CASES $25 REMEDY REFILLS:$10

PLEASE READ THE FOLLOWING CAREFULLY *if under 18 years, a parent or guardian must sign

I, the undersigned, understand that Eva Sidoti is a Homeopath. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions from a Medical Doctor. In consulting with Eva Sidoti, 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, the undersigned, do hereby acknowledge that the Homeopath named above has explained the homeopathic assessment and recommended treatment plan. I have been given the opportunity to ask questions about the homeopathic assessment and recommended treatment plan, and received answers to those questions. I confirm that I understand the homeopathic assessment and recommended treatment plan, which included a discussion of the nature of the procedure, expected benefits of homeopathic treatment, potential risks and side effects, as well as the fee schedule for homeopathic consultations. I have also been informed of any alternative courses of action that I can take, and I understand that my consent can be withdrawn at any time during the course of homeopathic treatment. I understand that the information provided will be kept confidential.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

*If under 18 years old, a parent or guardian must sign.

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