**Vital Health Homeopathy Centre**

**Adult History Form**

**Confidential**

Date …………………………………………….

Name........................................................................................................................Age.........…Sex...............DOB.............………………………………………………

Address: ............................................................................................................................................ Post code.....................................................................
Phone: **H**:........................:……………………..……**W**:.......................................:………..…….……**Mob**:.............................................................................................

Email……………………………………………………..……………………………………………………
Occupation........................................................………………..……Marital Status:..................................Children…………………………………………………………

Health Fund……………………………………………………………………………………………………………………………………………………………………………………………………
GP’s name, address and contact number:

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Nearest friend or relative who may be called in an emergency:

Name: …………………………………………………..………………………………………. Relationship ………………………………………………………………………………………….

Address………………………………………………………………………………………… Phone Number ……………………………………………………………………………………..

**Please complete the following pages in as much detail as you can. Providing detailed information makes it easier to accurately assess you - no detail is too small!**

**What would you like to have treated**? List your complaints in order of importance

   1.……………………………………………………………………………………………………………………………………………………………………………………………………………………

   2.…………………………………………………………………………………………………………………………………………………………………………………………………………………..

   3.…………………………………………………………………………………………………………………………………………………………………………………………………………………..

   4……………………………………………………………………………………………………………………………………………………………………………………………………………………

   5 …………………………………………………………………………………………………………………………………………………………………………………………………………………..

Please list your symptoms, in order of severity. (First symptom the most severe)

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   **How and when did your symptoms start?**

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Do you have any other health problems? If yes, please list:

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Please list your current supplements – vitamins, minerals etc

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Please list all your **current** prescribed medications:
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Do you have any other health problems? If yes please list:

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What medical treatment(s) have you used so far?

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What natural therapies have you used so far?

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**General Health & lifestyle information.**

Please rate your energy levels (circle) No energy **0 1 2 3 4 5 6 7 8 9 10** High Energy

Symptoms during sleep? Please circle: Snoring, mouth breathing restless, sleepwalking, night sweats, perspiration, nightmares.

Any other symptom during sleep? ……………………………………………………………………………………………………………………………………………………………………………………………………….

Regular wakefulness?............. Time of waking?………………………….Reason for waking?………………………………………………………………

What position do you like to sleep in? ………………………………………………………………………………………………………………………………………..

How do you feel in the morning after waking? ………………………………………………………………………………………………………………………….

Do you have any drug, environmental, food, or other allergies? Please state……………………………………………………………………….. ……………………………………………………………………………………………………………………………………………………………………………………………………….

How do you tolerate hot weather?........................................................Cold weather?...............................................................................

Does any type of weather affect your symptoms? Please……………………………………………………………………………………………………….. describe………………………………………………………………………………………………………………………………………………………………………………………..

Which season do you feel most comfortable in? ………………………………………………………………………………………………………………………

How much alcohol do you drink?...............................................What type? ……………………………………………………………………………………

What type of exercise do you do? ………………………………………How often?……………………………………………………………………………………

**Digestion:**

Do you suffer: Pain □ Bloating □ Indigestion □ Burping □ Diarrhoea □Constipation □ Wind □

When do you get these symptoms in relation to eating? Before, during or afterwards?

…………………………………………………………………………………………………………………………………………………………………..

What are your favorite foods? …………………………………………………………………………………………………………………

Do you have any food cravings? If so, what are they and the time of day that you most crave them?

……………………………………………………………………………………………………………………………………………………………………….

List any foods that you really dislike or aggravates you:…………………………………………………………………………..

**Mental/Emotional**

Do you have any fears or phobias? (eg. heights, spiders, tunnels, snakes, the dark, public speaking, thunderstorms) ………………………………………………………………………………………………………………………………………………………………………………………………………

If anxious, what do you worry about? …………………………………………………………………………………………………….........................................

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Is there anything about yourself, apart from your presenting complaint, which you feel impedes your ability to enjoy life and which you would like to change?

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**Illness/Injuries**

Have you had: Please tick

|  |  |  |
| --- | --- | --- |
| □Mumps □Measles□Rubella□Chickenpox□Whooping cough □Pneumonia □Rheumatic□Polio□ Liver/gallbladder disease□ Hemorrhoids □ Kidney problems | □ Skin disorders□ Recurring headaches□Glaucoma□ Asthma □ Heart Problems □ High Blood Pressure□ Peptic Ulcer□ Arthritis □ Recurring backache□ Diabetes □ Nervous breakdown  | □Mononucleosis□ Tuberculosis□Venereal Disease□Frequent Colds or Infections □Any broken bones□Head injury□List any other illness or injuries: □□□ |

**Surgery/Hospitalizations When?**

□ Tonsils

□ Appendix

□ Gallbladder

□ Uterus

□ One or both ovaries

**Immunisations**

Have you had any of the following immunisations:

□ Polio

□ Diphtheria/pertussis/tetanus

□ Measles

□ Mumps

□ Smallpox

□ Tetanus booster

List any others:

**Medical History**

***An accurate******time line of your medical history*** is important. *Of what you can recall* - please include all traumas, stressful events, surgeries, hospitalisations, and courses of antibiotics.

0 - 5   yrs: …….......................................................................................................................................................................................................

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5 -10  yrs: ……........................................................................................................................................................................................................

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10 -20yrs ……............................................................................................................................................................................................,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

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20-30 yrs: …….......................................................................................................................................................................................................

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30-40 yrs: …….......................................................................................................................................................................................................

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40-50 yrs: …….......................................................................................................................................................................................................

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50 +……..........................................................................................................................................................................................................................

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**Family History**Please describe **all known diseases** of the following family members eg heart disease; high blood pressure; diabetes; cancer; skin problems (eg psoriasis); TB; allergies; mental illness; alcoholism

Mother ……………………………………………………………………………………………………………………………………………………………………………………………………….

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Father …………………………………………………………………………………………………………………………………………………………………………………………................

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Immediate family (brothers, sisters, grandparents, aunts and uncles)

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Please list medical tests you have had

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| --- | --- | --- | --- |
| **TYPE OF TEST** | **DATE** | **REASON** | **RESULT** |
| □ Blood test(s) |  |  |  |
|  |  |  |  |
|  |  |  |  |
| □ X Ray(s) |  |  |  |
| □ CT scan |  |  |  |
| □ Ultrasound |  |  |  |
| □ Hearing test |  |  |  |
| □ Other |  |  |  |
|  |  |  |  |
|  |  |  |  |
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***Anything else you would like to mention?***

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Thank you for taking the time to provide Vital Health with this information. This will allow the homeopath to have a complete understanding of the case. The treatment of chronic disease in homeopathy is time-consuming every care will be taken to ensure the best treatment is given to you.

*I understand that:*

I understand that Homeopathy is a safe complementary system of medicine and it works gently to stimulate the body’s own healing power.

I understand that there is no recommendation by the Homeopath to stop, vary, reduce or change any medication prescribed by my G.P. and If I intend to do so, that will be at my own choice and ***Vital Health Homeopathy Centre***  will not be liable for any consequences.

In accordance with the [Data Protection Act 1988](http://www.irishstatutebook.ie/1988/en/act/pub/0025/index.html) I can have access to my records on application. An administration fee may be incurred.

Any examination or treatment is on the basis of informed consent.

The initial consultation can take about 2 hours, follow up consultation can take up to 1 hour.

My case notes remain confidential, unless otherwise required under law, and are held securely.

The personal information supplied to ***Vital Health Homeopathy Centre*** may only be used in the future to supply me with information concerning new treatments being made available at this clinic that are specific to me.

Family medical history that is supplied has been supplied with the knowledge and approval of the person concerned.

Date:

Full Name:

Signature: