

The Gilead Centre

New Patient Intake Form

Patient's Full Name: _____

Name that Patient likes to be referred to as: _____

Date of Birth: _____ Sex: _____ Blood Type: _____
(mm/dd/yy)

Address: _____
Street # Street Name PO Box #

City Province Postal Code

Telephone Number: (h) _____ (w) _____

Facsimile Number: _____ E-mail: _____

Cell Phone Number _____

If we need to contact you, where is your preferred place of contact during business hours?

home work cell other

May we leave messages concerning appointment times? Yes No

Emergency Contact Information:

Full Name Relationship To Patient

Phone # _____ Alternate Phone # _____

Whom can we thank for referring you to our clinic?

What is the primary reason for your visit today?

Approximate date that you last felt really well from a health perspective? _____

What are your primary Health Concerns in order of importance to you?

- 1)
- 2)
- 3)
- 4)

What are some of the Stressors in your life (your child's life) right now (i.e. home, school, work, environmental)?

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What is the Emotional Climate of your home like right now?

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How would you describe your general state of health currently?

Excellent _____ Good _____ Fair _____ Poor _____

Have you ever sustained any serious medical injury? Yes _____ No _____

If yes, please describe the injury(s) and give approximate date(s):

Injury	Date

Have you ever had any hospitalizations? Yes _____ No _____

If yes, please indicate reason for hospitalization and approximate date(s):

Reason for Hospitalization	Date

Have you ever had any serious medical conditions? Yes _____ No _____

If yes, please describe and give approximate date(s):

Medical Conditions/Illness	Date

Are you aware of any allergies whether from medicine, environment? Yes _____ No _____
 If yes, please list known/suspected allergies as well as approximate time of identification.

Allergy	Date

Regimen

Do you eat three meals per day? Yes _____ No _____

What did you eat yesterday?

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack _____

Is this a typical eating pattern? Yes _____ No _____

Do you have any dietary restrictions (i.e. religious)? Yes _____ No _____

If yes, please explain: _____

Of the following fluids, which do you consume, and how often?

Fluid	Yes	No	Quantity
Water			
Juice			
Coffee			
Tea			
Milk			
Alcohol			

Do you awake refreshed and well? Yes _____ No _____

Average number of hours you sleep each night: _____

What is your usual bedtime? _____

Do you think that you sleep well? Yes _____ No _____

Describe your sleep (time, habits, restlessness, night terrors, sleep apnea, ease at falling asleep, sleeping routine)

Do you exercise? Yes _____ No _____

Type of Exercise	Frequency

Do you spend time outdoors?

Daily _____ Couple Times a Week _____ Weekly _____ Only if Necessary _____

Do you use recreational drugs? Yes _____ No _____

Type of Drug	Frequency

Do you smoke/ chew tobacco? Yes _____ No _____

Family History

Please indicate any family members who have had, or who currently have the following conditions:

Condition	Family member	Condition	Family member
Alcoholism		Cancer	
Allergies		Cataracts	
Arteriosclerosis		Celiac Disease	
Arthritis		Crohns/Colitis	
Asthma		Depression	
Bed wetting		Diabetes	
Birth Defects		Epilepsy	
Blindness		MS	
Heart Disease		Osteoporosis	
Hyperactivity		Ulcers	
Kidney Disease		Stroke	
Learning Disability		TB	
Mental Illness		Yeast Infections	

Have you had in the past or do you currently have any of the following conditions/symptoms?

Condition/Symptom	Past	Present	Condition/Symptom	Past	Present
Acne			Urgency to Void		
Allergies			Inability to Void		
Asthma			Frequent Urinary Infection		
Bronchitis			STDs		
Emphysema			Unusual Discharges		
Eczema			Painful Menses		
Hives			PMS		
Headaches			Joint Pain/Stiffness		
Migraines			Arthritis		
Dizziness			Osteoporosis		
Hayfever			Osteopenia		
Glaucoma			Broken Bones		
Cataracts			Muscle Weakness		
Hearing Loss			Joint Swelling		
Ringing in Ears			Back Pain		
Sinus Problems			Concussion		
Frequent Sore Throat			Varicose Vein		
Gingivitis			Thrombophlebitis		
Dental Cavities			Leg Cramps		
Goitre			Cold Hands/Feet		
Pneumonia			Fainting		
Wheezing			Seizures/Convulsions		
Difficulty Breathing			Paralysis		
Shortness of Breath			Loss of Memory		
Tuberculosis			Speech Problems		
Heart Disease			Thyroid Problem		
Angina			Diabetes		
High Blood Pressure			Hormone Therapy		
Low Blood Pressure			Anemia		
Heart Murmur/Palpitations			Easy Bleeding/Bruising		
Breast Lumps			Blood Transfusion		
Breast Pain			Leukemia		
Trouble Swallowing			Cancer		
Heartburn			Vaccine Reactions		
Unusual Thirst			Depression		
Unusual Hunger			Anxiety		
Nausea			Phobias		
Gas/Belching			Bipolarism		
Jaundice			Alcohol Abuse		
Liver Disease			Drug Abuse		
Gallbladder Disease			Insomnia		
Ulcers			Post Partum Depression		
Prolonged Diarrhea			HIV		
Bloody Stools			AIDS		
Constipation			ADD		
Indigestions			ADHD		
Hemorrhoids			PTD		
Endometriosis			OTD		
Hernia					
Kidney Stones					

Medications

Please list all Prescription Medications that you are currently taking:

Medication	Dose	Reason	Date Started

Please list all PAST Prescription Medications that you were taking:

Medication	Dose	Reason	Date Started

Please list all Vitamins/Supplements/Homeopathic Remedies that you are currently taking:

Medication	Dose	Reason	Date Started

Please list all other Over The Counter Medications that you are currently taking:

Medication	Dose	Reason	Date Started

Consent to Treatment

I, _____ hereby consent to Homeopathic treatment of myself/my child _____ by Homeopathic Doctor and Doctor of Medical Heilkunst Roxanne Harris DHHP, DMH, DynN, DynB, and/or those other licensed Heilkunstlers working with her, or in replacement of her, or by request of her. I voluntarily consent to diagnostic and therapeutic procedures including physical, mental, emotional, and spiritual aspects, except for the following _____. I understand that the Homeopath/Heilkunstler may not be able to anticipate and explain all risks and complications resulting from treatment and understand that expected results cannot be guaranteed.

Signature

mm/dd/yy

mm/dd/yy

Signature of Witness

mm/dd/yy

Signature of Homeopath/Heilkunstler

Blood Type	
Glandular Type	
Metabolic Type	
Constitutional Type	
Office Use Only	

Treating HD/DMH _____	Please Print Full HD's/DMH's Name
Date of Initial Intake Interview _____ mm/dd/yy	Signature HD/DMH _____ mm/dd/yy
Date File Closed _____ mm/dd/yy	HD/DMH _____
For Office Use Only	