**Svasthya Homeopathic Clinic Intake Form**

**Patient Information**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Gender:**  
  ☐ Male  
  ☐ Female  
  ☐ Other
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **City/State/Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Emergency Contact Name & Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

1. **Do you currently have any health conditions?**  
   ☐ Yes (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
2. **Are you currently taking any medications?**  
   ☐ Yes (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
3. **Have you had any surgeries or hospitalizations in the past?**  
   ☐ Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
4. **Do you have any allergies?**  
   ☐ Yes (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
5. **Do you have any history of the following conditions? (Please check all that apply)**  
   ☐ Diabetes  
   ☐ Heart disease  
   ☐ High blood pressure  
   ☐ Asthma  
   ☐ Arthritis  
   ☐ Depression  
   ☐ Anxiety  
   ☐ Hormonal imbalance  
   ☐ Digestive issues  
   ☐ Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Have you ever had any adverse reactions to homeopathic treatments or remedies?**  
   ☐ Yes (Please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No

**Lifestyle and Symptoms**

1. **What is your primary reason for seeking homeopathic treatment?**  
   (Please provide a brief description of your main concerns or symptoms.)
2. **How would you describe your overall energy levels?**  
   ☐ Low  
   ☐ Average  
   ☐ High
3. **How do you sleep?**  
   ☐ Restfully  
   ☐ Frequently wake up  
   ☐ Trouble falling asleep  
   ☐ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **What is your appetite like?**  
   ☐ Normal  
   ☐ Increased  
   ☐ Decreased  
   ☐ Cravings (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Do you have any sensitivities to temperature, weather, or food?**  
   ☐ Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
6. **How would you describe your stress levels?**  
   ☐ Low  
   ☐ Moderate  
   ☐ High
7. **Do you exercise regularly?**  
   ☐ Yes (Please describe your exercise routine) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No

**Additional Information**

1. **Have you received any previous homeopathic treatment?**  
   ☐ Yes (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   ☐ No
2. **Do you have any additional concerns or goals you'd like to address with homeopathy?**
3. **Is there anything else we should know to better assist you?**

**Consent and Agreement**

By signing below, I agree to the following:

* I understand that the information provided above is accurate to the best of my knowledge.
* I agree to follow the treatment plan and recommendations provided by the practitioner.
* I acknowledge that homeopathic treatments are individualized and that results may vary.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_