**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_