

**Homeoprophylaxis Intake Form**

Client’s Name

Street Address

City Province/State:

Postal Code:

Country

Mother’s Name (for child consults only)

Father’s Name (for child consults only)

Tel. Home: Tel. Office:

Date of Birth Present Age:

Siblings, names and ages (for child consults only)

Health Care Practitioners

Medical Doctor and phone number

Emergency contact and phone number

Email:

Would you like to receive my newsletter – sent about 4 times a year?

Who referred you to this office?

***Dear Client,***

***Welcome to my office. This questionnaire will help you to organize your thoughts for our initial meeting. Clients find the timeline especially useful. I am the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please contact the office and I will help you to decide how best to solve the issue.***

**ACKNOWLEDGMENT**

Sonya McLeod uses non-invasive methods for the assessment of bodily dysfunction, and natural therapeutics for their correction, mostly homeopathy.

In order to avoid any confusion or misunderstanding, I request that all clients read and acknowledge the following:

•That you understand that Sonya McLeod works within the homeopathic scope of practice, is not a medical doctor, and employs some methods which are not orthodox medical practice at this time.

initial

•That you understand that care here and/or referral to other health professionals is based upon the assessment revealed through personal history and interview, physical assessment and laboratory testing.

initial

•That you understand homeopathic care is not generally covered under MSP at the present time and, therefore, you are responsible for any fees incurred while under treatment. Homeopathic care is covered under many private insurance plans and I will do my best to provide the appropriate documentation for your insurer upon request.

initial

•That you are here as a client and are not attending my office for any other reason without making your intention known.

initial

**Please be informed that you are required to give at least 1 business day notice in case you need to cancel or reschedule any appointment, including the initial one. I regret that otherwise you will be charged for the missed appointment**.

I greatly appreciate your consideration in this matter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signature

**Consent for Care**

Sonya McLeod will take a thorough case history.

It is very important that you inform Sonya of any disease process that you/your child is suffering from and any supplements/medications/over the counter drugs that they/you are currently taking.

There are some health risks associated with the use of homeopathic remedies, and supplements. These include but are not limited to the following:

* Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
* Homeopathic remedies may stimulate healing or detoxification reactions, which may include loose stools, increased perspiration, skin eruptions and nasal discharges, among others. These reactions are relatively uncommon and normally pass within a few hours to days.
* Nutritional supplements sometimes cause stomach discomfort. Niacin-containing supplements may cause skin flushing and itching.
* Rarely, individuals may experience allergic reactions to certain supplements and herbs. Please advise Sonya immediately if you think that you/your child has experienced an allergic reaction.
* Please let Sonya know immediately should you/your child experience any negative side-effects from any of your homeopathic and wellness care.

## Important points to note:

* **Sonya McLeod does not guarantee treatment results.**
* A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law. You are entitled to a copy of your/your child’s records at any time and to transfer their records to another practitioner if desired.
* Sonya will explain to you the exact nature of any treatment provided and will answer any questions you may have to the best of her ability.
* You are free to withdraw your consent and to discontinue care at any time.

I certify that I have read and understood the above **Consent for Care.**

Patient/Guardian Name: (Please print name):

Signature of patient/guardian:

Date:

**Disclaimer**

Homeopathic remedies are always safe, non toxic and natural. Our remedies should never be confused for or conflated with pharmaceutical drugs, including vaccines.

Little Mountain Homeopathy offers no medical opinion to clients about whether or not they should decide to vaccinate. Clients are encouraged to weigh the pros and cons of their decision and to do as much of their own research as possible about the pros and cons of vaccination.

Health Canada has not authorized any NHP to treat, prevent or cure COVID-19 or any other disease.

I certify that I have read and understood the above **Disclaimer.**

Patient/Guardian Name: (Please print name):

Signature of patient/guardian:

Date:

**Confidential Client Information**

1. Please describe it in detail any health conditions that you/your child are currently dealing with. In your own words, list the very first time that you noticed these conditions and describe carefully any factors that you suspect may have played a role on their onset and development.

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2. What other objectives do you have as far as you/your child’s health is concerned?

3. Did the mother have any physical or mental health issues during the period of conception, during pregnancy, or labour? Please provide details (for child consults only)

4. Please list any medication that you/your child are currently taking including natural supplements and homeopathy. For child consults, please list any medication the mother was taking during conception or during pregnancy or while breastfeeding.

5. Are you/is your child vaccinated? If so please give a timeline of all vaccines given and list reactions, if any.

5. Are you/your child currently working with a professional counselor, psychologist, social worker, or other health professional? Please provide details:

5. Have you/your child had homeopathic care before? Please provide details:

# FAMILY HEALTH HISTORY

## Please indicate below which of the following ailments, or any other ailments, have affected your child’s relatives. Please attach additional pages if needed. Include any peculiar characteristic of relatives who are similar to your child in any way.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Alcoholism** | **Asthma** | **Epilepsy** | **Heart Dis.** | **Paralysis** | **Syphilis** |
| **Allergies** | **Cancer** | **Gonorrhoea** | **Hypertensn.** | **Pneumonia** | **Thyroid**  |
| **Alzheimer's** | **Depression** | **Gout** | **Kidney Dis.** | **Skin Dis.** | **Disorder** |
| **Arthritis** | **Diabetes** | **Hay Fever** | **Mental Illness** | **Digestive**  | **Tuberculosis** |
|  |  |  |  | **Disorders** |  |
| **RELATIVE** | **AGE if alive** | **AGE if death** | **AILMENTS** |
| **Mother** |  |  |  |
| **Father** |  |  |  |
| **Brothers** |  |  |  |
| **Sisters** |  |  |  |
| **Maternal Grandmother** |  |  |  |
| **Maternal Grandfather** |  |  |  |
| **Maternal Aunts/Uncles** |  |  |  |
| **Paternal Grandmother** |  |  |  |
| **Paternal Grandfather** |  |  |  |
| **Paternal Aunts/Uncles** |  |  |  |

Thank you for completing this questionnaire. Please let me know if you would like a copy of your work, many people have found this very useful for further reference.

Sonya McLeod, BA, DCH