SHAH HOMEOPATHIC CLINIC

Phone: 2269299310
307 Scott Blvd, Milton, Ontario
L9T 6Z7

Patient Intake Form
Please fill in the form carefully. Choose one option where applicable.

PATIENT INFORMATION

Patient # Full Name

Date Age / DOB

Phone Email

MAIN COMPLAINT

Do you have a main health concern? **Yes** **No**

Since when **Cause (if known)**

Type (Acute / Chronic)

MENTAL & EMOTIONAL

Anxiety? **Yes** **No**

Fear? **Yes** **No**

Depression / low mood? **Yes** **No**

Recent stress / trauma? **Yes** **No**

Please write all related details in the summary section.

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Please write all details in the summary section.

SLEEP

Sleep problems? **Yes** **No**

Hours of sleep **Dreams?** **Yes** **No**

GENERAL SYMPTOMS

Appetite issues? **Yes** **No**

Thirst issues? **Yes** **No**

Sensitivity to heat / cold? **Yes** **No**

SYSTEM REVIEW

Digestive issues? **Yes** **No**

Respiratory issues? **Yes** **No**

Urinary issues? **Yes** **No**

Heart / BP issues? **Yes** **No**

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Patient Intake Form
Please complete the medical history and medicine sections.

MEDICAL HISTORY

Past diseases?	**Yes**	**No**
Surgeries / hospitalizations?	**Yes**	**No**

MEDICATIONS

Taking any medicines?	**Yes**	**No**

SUMMARY SECTION

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Homeopathic Consent Form
Please read and complete the consent section before signing.

CONSENT

CONSENT

Homeopathy is a complementary and alternative approach that considers the patient's physical, mental, and emotional state as part of the overall case-taking process.

Homeopathic care is not a substitute for conventional medical treatment.

Please continue any treatment, medication, testing, and precautions advised by your family physician or other licensed healthcare provider.

For any urgent or emergency situation, call 911 immediately or go to the nearest hospital.

Do not stop prescription medication without the direction of the prescribing clinician.

You may choose to withdraw consent and discontinue homeopathic care at any time.

I have read and understood the consent information above and agree to homeopathic care.

Patient / Guardian Name: _____

Date: _____ **Signature:** _____

Patient / Guardian Name: _____

Date: _____ **Signature:** _____

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Patient Intake Form
Homeopath notes section

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HOMEOPATH NOTES