Vital Force Homeopathy

NEW CLIENT # _____ DATE OF VISIT: _____

NAME : _____

DOB: _____ SEX: ____ MARITAL STATUS: _____

CHILDREN: _____ OCCUPATION: _____

EMAIL: _____

ADDRESS: _____

PHONE: (DAY) _____

(EVE.) _____

MINORS (guardian): _____

NAME/ TELEPHONE OF PHYSICIAN: _____

FAMILY HISTORY:

Has any blood relative had any of the following? Please indicate their relationship to you.

Alcoholism	Diabetes	Kidney Disorder
Allergies	Drug Addiction	Nervous Disorder
Arthritis	Bleeding Disorder	Psoriasis
Asthma	Eczema	Thyroid Disorder
Cancer	Glaucoma	Tuberculosis
Mental Illness	Heart Disease	OTHER

YOUR HEALTH HISTORY:

Medications:

Dates: _____ Cortisone/ Steroids	Dates: _____ Hormone Therapy
Dates: _____ Antidepressants	Dates: _____ ARV's
Dates: _____ Birth Control Pills	Dates: _____ Antibiotics
Dates: _____ Other	Dates: _____ Other

Vaccinations:

Hepatitis _____ Influenza _____ Other _____

Any reactions to medications or vaccinations.

Illnesses:

Date: _____ Alcoholism
Date: _____ Allergies
Date: _____ Arthritis
Date: _____ Back Pain
Date: _____ Cancer
Date: _____ Depression
Date: _____ Diabetes
Date: _____ Drug Addiction
Date: _____ Eczema
Date: _____ Glaucoma
Date: _____ Heart Disorder
Date: _____ Hepatitis
Date: _____ Hyper or Hypotension
Date: _____ Influenza
Date: _____ Infertility
Date: _____ Menstrual Disorder
Date: _____ Nervous Disorder
Date: _____ Pneumonia
Date: _____ STD's
Date: _____ Thyroid Disorder

Surgeries and hospitalizations:

_____
_____
_____
_____
_____
_____

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