Homedica Holistic Health

Patient Last Name

Patient First Name

Address

City | Province | Postal Code

Home Phone | Mobile Phone

Email

Date of Initial Consultation _____

Date of Birth | Sex | Height

Weight | Hair Colour | Eye Colour

Family Doctor _____

Address | City

Province | Postal Code

Phone | Fax

REFERRAL POLICY:
Any patient that kindly refers another individual to me will themselves receive a gift card.

Referred by:

Name:

Phone:

Email:

I, _____, the undersigned, understand that Jocelyn McTavish is not a licensed medical doctor, but instead a Classical Homeopath. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Jocelyn McTavish, to seek medical counsel and diagnosis, if so desired from a licensed medical doctor, for any present and/or future condition(s). I also reserve the right to terminate homeopathic treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its entirety.

Patient's Signature:

Date:

If under 18 years of age, a parent or guardian must sign on your behalf.

FEE SCHEDULE
Homeopathy is not covered by existing government medical insurance plans, therefore I agree to pay all fees incurred as presented in the current rate schedule below (rates are subject to change).

- **Initial appointment $180 HST Incl** (2hrs)
- **Follow-up appointment $60+HST** (30min)
- **Acute appointment $60+HST** (30min)

PAYMENT
- All fees are payable at the end of each visit (cash or cheque only)
- Fees do not include HST
- There will be an $8.00 shipping fee (via Express Post) if the remedy is mailed to the patient

MISSED APPOINTMENT POLICY:
24 hours notice is needed if an appointment is to be missed otherwise there will be a charge for the full amount of the missed appointment.

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Major medical Complaints (In order of importance)

1. Since Causes
2. Since Causes
3. Since Causes
4. Since Causes

MEDICAL HISTORY

Major Injuries

Type: Age:

Type: Age:

Type: Age:

Surgeries

Type: Age:

Type: Age:

Type: Age:

Sexually Transmitted Diseases

Type: Age:

Type: Age:

Inidcate which of the following conditions you've had/have:

Abscesses, AIDS/HIV, Alcoholism, Anemia, Anxiety disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold sores, Colitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Gallstones, Goitre, Gonorrhea, Gout, Hay fever, Heart disease, Hepatitis, Genital Herpes, Influenza, Kidney disease, Leukemia, Malaria, Measles, Miscarriage, Mononucleosis, Mood disorder, Mumps, Parasites, Pleurisy, Pneumonia, Post-partum depression, Prostatitis, Rheumatic fever, Rubella, Scarlet fever, Schizophrenia, Schizoid-affected disorder, Sexual abuse, Skin disease, Strep throat, Sinusitis, Stroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping Cough, Worms, Yellow fever

Vaccination History/Childhood Illnesses

☐ Diptheria

Age when vaccinated for: Age when/if ill with:

☐ Pertussis (whooping cough)

Age when vaccinated for: Age when/if ill with:

☐ Tetanus

Age when vaccinated for: Age when/if ill with:

☐ Measles

Age when vaccinated for: Age when/if ill with:

☐ Mumps

Age when vaccinated for: Age when/if ill with:

☐ Rubella

Age when vaccinated for: Age when/if ill with:

☐ Chicken Pox

Age when vaccinated for: Age when/if ill with:

☐ Other

What?

Age when vaccinated for: Age when/if ill with:

What?

Age when vaccinated for: Age when/if ill with:

Any adverse affects from vaccinations?

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Any other major conditions?

Have you experienced any serious emotional or physical trauma? (shock/grief/disappointment)

Are there any of the preceding conditions after which you have never been totally well again? Which one(s)?

Do you participate in planned exercise? What type of planned exercise(s)?

How much of the following substances are you using?

Tobacco: Alcohol: Coffee: Recreational Drugs:

If you are a non-smoker – Do you live with a smoker? How many years?

What is your stress level?

☐ Low ☐ Average ☐ Considerable ☐ Unbearable

What are the major causes of your stress? (Marital/Financial/Career/Family/Health/Unfulfilled expectations)

How does stress manifest in you? How do you cope with stress?

How many hours a night do you sleep? Do you awaken feeling rested?

What is your occupation? Do you enjoy your work? (Yes/No/Sometimes)

How many hours a day do you work? Do you take work home with you? (Yes/No/Sometimes)

How many hours on average do you spend:

Commuting/Driving Reading Watching TV/Video Games Computer

Do you have any hobbies? Do you practice any spiritual discipline?

Do you vacation regularly? When was your last vacation?

Have you lost/gained weight? Do you wish to lose or gain weight?

How much would you like to lose or gain? How often do you eat? (3 meals / 3 snacks)

Do you eat meals: Alone/Family/Friends/On the run? Favourtie Foods?

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Sexual Health

Female, what was the age of your first menses: Method of Birth Control? How long?

Previous pregnancies/miscarriages/abortions or complications: Could you pregnant or menopausal?

Male, any history or impotence/erectile dysfunction/prostate/urination problems? When?

Treatment for any of the above:

How often do you have a bowel movement? ☐ 1-2x/day ☐ 1-3x/week ☐ about 3x/month

Do you strain to have abowel movement? Do you have mucous on the bowel movement?

Do you have mercury fillings? ☐ Yes ☐ No Have you ever had periodontal issues? ☐ Yes ☐ No

Have you ever used or been treated with homeopathic medicine?

Homeopath When

For what condition(s)

FAMILY HEALTH HISTORY

Heart Disease, Hypertension, Intestinal Disease (IBS/IBD), Diabetes, Allergies, Eczema, Arthritis, Mental Illness, Osteoporosis, Asthma, COPD, Cancer, GallBladder, Ulcers, Kidney Dysfunction, Alcoholism, Addison's Disease

	Age if alive	Age at death (cause)	Major Ailments
Mother			
Father			
Sister(s)			
Brother(s)			
Mat. Grandmother			
Mat. Grandfather			
Mat. Aunts/Uncles			
Pat. Grandmother			
Pat. Grandfather			
Pat. Aunts/Uncles			

Is there anything else you feel is of importance to mention? _____

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.