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 and Holistic Nutritionist. 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 or nutritional 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 and nutrition, 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 $200+HST** (2hrs)
- **Follow-up appointment $80+HST** (30min)
- **Acute appointment $80+HST** (30min)

PAYMENT

- All fees are payable at the end of each visit (Visa, MasterCard, EFT, cash or cheque)
- 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

YOUR MEDICAL HISTORY

Major Injuries

Type: Age:

Type: Age:

Type: Age:

Surgeries

Type: Age:

Type: Age:

Type: Age:

Sexually Transmitted Diseases

Type: Age:

Type: Age:

Indicate which of the following you've had/have:

Abscesses, AIDS/HIV, Alcoholism, Anemia, Anxiety disorder, Arthritis, COPD, Asthma, Cancer, Chicken pox, Cholera, Cold sores, Colitis, Cystitis, Depression, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Fibroids- breast/uterine, 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, Thyroid issues, Tonsillitis, Tuberculosis, Typhoid

Vaccination History/Childhood Illnesses

☐ Unvaccinated

☐ Partially Vaccinated, Which Vaccinations? Check below

☐ Fully Vaccinated

Any adverse affects from vaccinations?

☐ **Diptheria**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Pertussis**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Tetanus**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Measles**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Mumps**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Rubella**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Chicken Pox**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Flu Shot**, Age of vaccination or illness

_____Vaccinated _____Had Illness

☐ **Other? Which one:** Guardasil, TwinRix, MenC/C-A/Y/W, HPV, Pneumonia, Hep-B, Yellow-fever, Malaria _____

Age of vaccination or illness

Vaccinated Had Illness

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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 or illnesses after which you have never been totally well again? Which one(s)?

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

How much of the following substances are you using? Be honest!

☐ Tobacco: _____ ☐ Alcohol: _____ ☐ Coffee: _____ ☐ Recreational Drugs: _____

Quit? **Y** / **N** How long ago? If you are a non-smoker that lives with a smoker? **Y** / **N** If so, how many years?

What is your stress level? ☐ Low ☐ Average ☐ Considerable ☐ Unbearable

What are the major causes of your stress

☐ Marital/Relationships ☐ 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 or gained weight? Do you wish to lose or gain weight? If so how much?

How often do you eat? (3 meals / 3 snacks) Do you eat meals: Alone/Family/Friends/On the run?

Favourite 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 be pregnant or menopausal?

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

FEMALE / MALE treatment for any of the above issues?

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

Do you strain to have a bowel 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?

Parent/Homeopath/Naturopath _____ **Y** / **N** When _____

For what condition(s) _____

FAMILY HEALTH HISTORY - Indicate those that apply.

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	Major Ailments
Mother			
Father			
Sister(s)			
Brother(s)			
Mat. Grandmother			
Mat. Grandfather			
Mat. Aunts/Uncles			
Pat. Grandmother			
Pat. Grandfather			
Pat. Aunts/Uncles			