(647) 780-5221 Milva Petrova HOM DCHM

milva.homeopathy@gmail.com
www.milvahomeopathy.com

Homeopathic Consultation
New Patient Intake Form

I, ……the undersigned, understand that Milva Petrova HOM, is a Registered Homeopath and not a medical doctor. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Milva Petrova HOM, to seek medical consultation and diagnosis. I am free to do so from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate my homeopathic treatment at any time. I acknowledge that the state of my health is my own responsibility and that I am performing my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its entirety. I consent that after assessment, answering of questions, and discussion of treatment options, to my satisfaction, I will voluntarily follow recommended treatment advice. I understand I can withdraw my consent at any time. I understand that the information provided from me will be kept strictly confidential for 10 years after my last visit and used only for the purposes of my care.

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.

Patient's Parent/Custodian Signature: ..……..

Date: …….

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

Patient Last Name ……..

Patient First Name …….

Date of Birth ……..

Sex ……..

Address ……..

City Province Postal Code ……

Phone …….....

Email ……..

Family Doctor …….

Address City ……

Province Postal Code ……..

Phone ……..…

Date of Initial Consultation ……

Referred by: ……

Occupation: …….

Employer: …….

Health Insurance Provider:……..

Health Insurance Policy number…….

(647) 780-5221 Milva Petrova HOM DCHM

milva.homeopathy@gmail.com
www.milvahomeopathy.com

Major medical complaints (In order of importance)

1. ……Since……

Cause ….……..……

2. ……Since……..…

Cause ….……..……

3. ……Since……..…

Cause ….……..……

4. ……Since……..…

Cause ….……..……

What medications is your child currently taking?

Medication Since Adverse effects

…….
…….
…….

Is your Child Currently Under the Care of a Physician(s)?

Physician Condition? Treatment(s)?

…….
…….
…….

What other treatments or regimes is your child currently following?

…….
1. Since Results

……
2. Since Results

……
3. Since Results

Circle any of the following conditions your child had or has:

Abscesses, Allergies, Anemia, Anxiety disorder, Arthritis, Asthma, Cancer, Chicken pox, Cold sores, Colitis, Diabetes, Eating disorder, Eczema, Emphysema, Epilepsy, Hay fever, Heart disease, Hepatitis, Influenza, Kidney disease, Leukemia, Malaria, Measles, Mononucleosis, Mood disorder, Mumps, Parasites, Pleurisy, Pneumonia, Rubella, Scarlet fever, Sexual abuse, Skin disease, Strep throat, Sinusitis, Sun Stroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid fever, Venereal warts, Warts, Whooping Cough, Worms, Colics, Thrush , Frequent colds

(647) 780-5221 Milva Petrova HOM DCHM

milva.homeopathy@gmail.com
www.milvahomeopathy.com

Vaccination History & Childhood Illnesses

□ Diphtheria
Age when vaccinated: Age when/if ill:

……
……

□ Pertussis (whooping cough)
Age when vaccinated: Age when/if ill:

……
……

□ Tetanus

Age when vaccinated: Age when/if ill:

……
……

□ Measles

Age when vaccinated: Age when/if ill:

……
……

□ Mumps

Age when vaccinated: Age when/if ill:

……
……

□ Rubella

Age when vaccinated: Age when/if ill:

……
……

□ Chicken Pox

Age when vaccinated: Age when/if ill:

……
……

□ Other What? ……...……...

Age when vaccinated: Age when/if ill:

……
……

Any adverse affects from vaccinations? …….....

Has your child had any major INJURIES?

.....
Type: Location: Age:

.....
Type: Location: Age:

What SURGERIES your child had, if any?

Type: Location: Age:

.....
Type: Location: Age:

Previous pregnancies by natural mother, miscarriages or complications?

.....

.....

Mother's age at child birth …….....

(647) 780-5221 Milva Petrova HOM DCHM

milva.homeopathy@gmail.com
www.milvahomeopathy.com

Mother's health during the pregnancy? List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption etc…….

……

Birth history: which gestation week the child was born: …….. **Weight at birth** of the baby:.……

Length of labour: ……. Were any complications: …….

At what age did your child begin to: Sit down……Crawl…… Walk…… Say first words……

Breastfed? …… How long? …… **Formula**? …… Milk/Soy or other? ……

Food intolerances? What food? ……. Age began solid foods? ……..

Are there any conditions, after which your child had never been well since?.....

Health History of Relatives
Alcoholism, Allergies, Arthritis, Asthma, Cancer, Depression, Diabetes, Epilepsy, Gonorrhea, Gout, Hay fever, Heart disease, Mental Illness (specify type), Paralysis, Pneumonia, Skin disease, Syphilis, Tuberculosis, or ANY OTHER MAJOR AILMENTS:
…….…..

Relative relationship	**Alive (yes/no)**	**age**	**Ailment / disease**	**Cause of death if deceased**
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				
Brothers/ sisters of the mother				
Brothers/ sisters of the father				
Mother				
Father				
Sister(s)				
Brother (s)				

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT TO YOUR CHILD CASE THAT YOU WOULD LIKE TO SHARE?.....

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