Health and Healing Homeopathy Consultation Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: D\_\_\_\_\_\_\_ M\_\_\_\_\_\_\_ Y\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:  Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present M.D. and Phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major Complaints in Order of Importance For You:**

|  |  |  |
| --- | --- | --- |
| **Complaint** | **Since** | **Causes** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Which Medications Are You Currently Taking?**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Since** | **Adverse Effects** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 **What Other Treatments or Regimes Are You Currently Following?**

|  |  |  |
| --- | --- | --- |
| **Treatment or Regime** | **Since** | **Results** |
|  |  |  |
|  |  |  |
|  |  |  |

 **Which Of The Following Conditions Have You Had?**

Abscesses Alcoholism Allergies Amnesia Anemia Arthritis Asthma

Cancer Chicken Pox Cold Sores Colitis Depression Diabetes

Emphysema Epilepsy Gall Stones Goitre Gonorrhea Gout

Hay Fever Heart Disease Hepatitis/Herpes Influenza Kidney Disease Leukemia Malaria

Measles PCOS Miscarriage Mononucleosis Mumps Parasites

Pelvic Inflammatory Disease Pleurisy Pneumonia Prostatitis Rheumatic Fever Rubella

Scarlet Fever Sexual Abuse Skin Disease Strep Throat Sinusitis Stroke Sun Stroke Thyroid issues Tonsillitis Tuberculosis Warts Whooping Cough

Worms Yellow Fever

**Any Other Major Conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
Are there any of the preceding conditions after which you have **never been well since?**

Which Ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women)Age of first Menses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women)Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **Have you been vaccinated and if so for which of the following? Please circle all that apply. If you know you have been vaccinated but cannot remember for what please just state yes or no.**Measles Mumps Rubella/German Measles Chicken Pox Whooping Cough

Pneumonia Mononucleosis Hepatitis A/B/C Yearly Flu Shots

**Are You Currently Under the Care of a Physician(s)?**

Physician                 For Which Condition?        Treatments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Any serious shock, grief, disappointment, fright, depression, etc?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **What Major Operations Have You Had?**

|  |  |  |
| --- | --- | --- |
| Operation | When | Complications |
|  |  |  |
|  |  |  |

**What Major Injuries Have You Had?**

|  |  |  |
| --- | --- | --- |
| Injury | When | Complications |
|  |  |  |
|  |  |  |
|  |  |  |

**Please CIRCLE on the diagram any areas of concern**



**How Much of the Following Substances Are You Using?**

Tobacco\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:**

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes

Epilepsy Gonorrhea Gout Heart Disease Insanity Paralysis Pneumonia

Skin Disease Syphilis Tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative** | **Age if alive** | **Age at death** | **Ailments** |
| **Mother** |  |  |  |
| **Father** |  |  |  |
| **Brothers** |  |  |  |
| **Sisters** |  |  |  |
| **Children** |  |  |  |
| **Maternal Grandmother** |  |  |  |
| **Maternal Grandfather** |  |  |  |
| **Maternal Aunts/Uncles** |  |  |  |
| **Paternal Grandmother** |  |  |  |
| **Paternal Grandfather** |  |  |  |
| **Paternal Aunts/Uncles** |  |  |  |

**Is there any other information that I would need to know?**

**Medical/Professional Waiver**

PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.) I, the undersigned, understand that Meghan Manzo is a homeopathic practitioner and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Meghan Manzo, I am exercising my right to choose an alternative method of treatment through which to address my total health. I agree to pay all fees presented in the current rate schedule. I understand that a no show fee of $50 will be applied if an appointment is missed. I acknowledge that all personal information will be kept confidential.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card #:­­­­­­­­­­­**

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**Expiry:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ CVV:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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