Homeopathy
Holistic Health Care

**Palma Cicco, Hom, DCHM (Hons)**
Telephone: 905- 266-2199 | Mobile: 647-838-7948
Fax: 905-266-2155

# ADULT HOMEOPATHIC CONSULTATION FORM

Name: ____________________________________________ Date of Birth: (D) _______ /(M) ________ /(Y) ________

Address: ____________________________________________________________________________
Street City Postal code

Telephone: Home: ______________________ Work: _____________________ Mobile: __________________

E-mail address: ______________________________________________________________________

Referred By: ______________________ Family Doctor & Phone no.: _____________________________________

Allergies: _________________________

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

| Complaints | Since | Causes |
|---|---|---|
| | | |
| | | |
| | | |

**Which Medications Are You Currently Taking?**

| Medications | Since | Adverse effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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

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

**Please Circle Any of the Following Conditions You Have Experienced.**

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 | Miscarriage |
| Mononucleosis | Mumps | Parasites | Pelvic Inflammatory Disease | | PCOS | 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 not been totally well again?
Which Ones? _________________________________________________________________________

(Women) Age of first Menses: _________________ (Women) Number of Pregnancies: __________________________

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

| Physician | For Which Condition? | Treatments |
|---|---|---|
| | | |
| | | |
| | | |

**What Major Operations Have You Had?**

| Operations | When | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**What Major Injuries Have You Had?**

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

**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 of Death | Ailments |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Brother/Sister | | | |
| Son/Daughter | | | |
| Grandmother/Grandfather | | | |

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

**Medical/Professional Waiver**

**PLEASE READ THE FOLLOWING CAREFULLY (If under 19 years of age, a parent or guardian must sign).** I, the undersigned, understand that *Palma Cicco* is a homeopath 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 *Palma Cicco*, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that “symptoms” from my consultations may be used for homeopathic teaching purposes.
I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from *Palma Cicco* and/or *Osteopathic Health Centre Clinic* which will provide me with confirmation of appointments, relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these emails at any time.

**Patient Signature:** _____________________________________________ **Date:** ____________________________