Linda Latta D.C.H.M., C.N.P.

Homeopathic Medicine ~ Holistic Nutrition

Intake Form

Date: _____ Date of Birth: _____

Name: _____ Age: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Cell: _____ Email: _____

Occupation: _____

Occasionally e-mails are sent out with new information or health seminar dates, may we include you? YES /NO?

What are your <u>CHIEF CONCERNS</u> in order of priority? Since when?

_____

_____

_____

Can you trace the origin of your illness to any particular circumstance, accident, illness, incident or mental upset? (e.g., shock, worry, dietary, overexertion, weather)?

_____

_____

Known ALLERGIES: (diagnosed or experienced) _____

Are you, or could you be pregnant? _____ Do you wear a pace-maker? _____

Are you currently taking any <u>MEDICATIONS</u> or <u>SUPPLEMENTS</u>? Please list all.

_____

_____

_____

Please list any major <u>SURGERIES</u> you have had in the past including dates:

_____ _____

_____ _____

Have you had any <u>INJURIES</u>? **When?**

_____ _____

_____ _____

What <u>VACCINATIONS</u> have you had? Did you/do you have any adverse reactions? YES/ NO

_____

Have you lost any weight recently? YES/NO **How much? _____**

Please check which of the following substances you are currently using:

Alcohol	How much? _____	**Pain Killers**	How much? _____
Chewing Tobacco	How much? _____	**Recreational Drugs**	How much? _____
Cigarettes	How much? _____	**Sleeping Pills**	How much? _____
Coffee	How much? _____	**Supplements/Herbs**	How much? _____
Tea	How much? _____	**Laxatives/Purgatives**	How much? _____

Please check which of the following you have experienced or are suffering from <u>now</u> (N) or in the <u>past</u> (P):

__ Abortion	__ Diabetes	__ Hypertension	__ Measles	__ Rheumatic Fever	__ Venereal Warts
__ Alcoholism	__ Eczema	__ Hepatitis	__ Miscarriage	__ Sexual Abuse	__ Warts
__ Allergies	__ Epilepsy	__ Herpes	__ Mononucleosis	__ Skin Disease	__ Whooping Cough
__ Anemia	__ Emphysema	__ Influenza	__ Mumps	__ Strep Throat	__ Worms
__ Appendicitis	__ Gall Stones	__ Jaundice	__ Nosebleeds	__ Sinusitis	__ Yellow Fever
__ Asthma	__ Goiter	__ Kidney Disease	__ Ovarian Cysts	__ Stroke	__ Yeast Infections
__ Cancer	__ Gonorrhea	__ Pneumonia	__ Parasites	__ Syphilis	
__ Chicken Pox	__ Gout	__ Leukemia	__ Tonsillitis	__ Thyroid problems	Other:
__ Cold Sores	__ Hay Fever	__ Liver Disease	__ Prostatitis	__ Tuberculosis	_____
__ Depression	__ Heart Issues	__ Malaria	__ Psoriasis	__ Urticaria	_____

Diet Diary → This is a snapshot to give an idea of the types of foods/variety you consume

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							

Have you obtained the services of a Homeopath or Naturopath in the past? YES/NO
IF YES – Please list all homeopathic remedies that you have taken OR are presently taking?

_____

Please list any other natural health practitioners that you are now seeing: (ie/Chiropractor etc.)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

FAMILY PHYSICIAN (name and tel #): _____

EMERGENCY CONTACT: _____ PHONE: _____

CLIENT CONSENT

I, _____, confirm that the above information was answered to the best of my ability.

Signature _____ Date: _____

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

Client Acknowledgement

MEDICAL/PROFESSIONAL WAIVER

PLEASE READ THE FOLLOWING CAREFULLY → *if under 18 years, a parent or guardian must sign.

I hereby attest to the following:

I fully understand that Linda Latta is not a medical doctor and I am not here for a medical diagnosis. If I have any health problem, health condition, or disease, I am now being advised not to postpone or delay seeking medical advice from a licensed doctor of allopathic medicine. I understand and agree that any service rendered by a Homeopath or Holistic Nutritionist is not designed to take the place of any conventional medical treatment.

All suggestions regarding specific foods, herbs, homeopathic remedies or nutritional supplements are part of an overall program to help the body normalize itself, to build and maintain wellness, and to support total well-being. They are not intended for the treatment of specific disease.

In consulting with Linda Latta, I am exercising my right to choose an alternative method of treatment through which to address my total health. As *Homeopathy* or *Holistic Nutrition* may or may not be covered by my medical insurance plan, I agree to pay all fees presented in the current rate schedule, payable to Linda Latta directly.

Payment can be made by cash or credit card at the end of each visit. Official receipts will be issued at time of paid service.

I have read and understand all the information outlined above.

Patient Signature: _____ Date: _____

Name of Guardian if under 18 years old: _____

****Cancellation Policy****

24hrs advanced notice is required for all missed appointments in order to wave appointment fee