yuma homeopathy

Help your body heal itself!

ADULT REGISTRATION FORM

Name: _____
Last First Middle Initial

Date of Birth: _____ **Sex: M F**

Email:_____ **Skype address:**_____

Address:_____
Street City State Zip

Telephone: Day: _____Evening:_____Cell:_____

Occupation/Employment:_____

Education: Grade school High school College Graduate/Post-graduate

(please indicate highest level attained)

Current personal Status (please choose one):

Single Married Divorced Separated Widowed In a relationship

If you have children, please list names and dates of birth: **No children____**

1._____ 4._____

2._____ 5._____

3._____ 6._____

Name of Person to be contacted in case of emergency:_____

Telephone/Cell:_____

Address:_____

Relationship to you:_____

How did you learn about us?_____

Physician/Primary Care Provider:_____
Phone

What would you most like homeopathic treatment to improve or prevent? _____

_____

1. Please list ALL MEDICATIONS AND SUPPLEMENTS you are CURRENTLY TAKING (including prescription drugs, nonprescription medicines, homeopathic remedies, herbs, vitamins, mineral supplements, teas, etc.)

Name	Date Started	Dosage/ Frequency	Reason

2. Please list all ALLERGIES you have been informed of by a medical professional (drugs, foods, pollen, ragweed, etc.):

1._____ 4._____

2._____ 5._____

3._____ 6._____

3. Please list all SURGERIES & HOSPITALIZATIONS:

Year	Reason

4. Have you previously sought ALTERNATIVE OR COMPLEMENTARY MEDICAL CARE? Yes No

- - - - -> If Yes, please list names, dates and services sought**:**

1._____

2._____

3._____

5. Have you ever had a REACTION or PROBLEMS FOLLOWING a VACCINATION? Yes No

Never been vaccinated _____

- - - - -> If Yes, please describe these problems:_____

_____

6. Have you ever had a REACTION or PROBLEMS FOLLOWING A MEDICATION? Yes No

- - - - -> If Yes, please describe these problems:_____

_____

7. Please check all CURRENT AND PAST ILLNESSES in your FAMILY and indicate CAUSE OF DEATH where relevant:
[Check here if you don't know anything about your family medical history ___]

ILLNESS	Parent	Sister/ Brother	Children	Grandparent	Check if CAUSE OF DEATH
Abnormal periods					
Alcohol/Drug abuse					
Allergies					
Anemia					
Arthritis/Gout					
Asthma					
Bleeding problems					
Cancer					
Diabetes					
Eczema					
Emphysema					
Epilepsy					
Frequent Infections					
Heart trouble					
Hepatitis					
High blood pressure					
Kidney problems					
Mental illness					
Migraines					
Polio					
Pneumonia					

ILLNESS	Parent	Sister/ Brother	Children	Grandparent	Check if CAUSE OF DEATH
Prostate Problems					
Psoriasis					
Rheumatic fever					
Stomach problems					
Stroke					
Thyroid problems					
Tuberculosis					
Ulcers					
Venereal disease					
Weight problems					

8. Please list all current diagnoses you have been informed of by a medical professional:

1._____ 4._____

2._____ 5._____

3._____ 6._____

7._____ 8._____

9. WOMEN Only:

a) Are you pregnant now? Yes No

- - -> If Yes, How many weeks?_____

b) Past pregnancies:

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of premature births_____

Number of abortions _____ Number of Caesareans _____

Thank you for your time and cooperation in completing this form!