Los Angeles Homeopathy Clinic **Clinic In-take form-Adult**

There is a 5 day Cancelation policy

Personal Health Questionnaire

All information will remain strictly confidential. Homeopathy helps balance the whole person on a physical, emotional and mental level. Please be as open and precise as you can.

Thank you for your trust and patience. Please print clearly

Date:_____**Marital Status:** _____

Name:_____

DOB: M/D/Y_____ **Age:**_____ **Place of Birth:**_____

Address_____

Phone: H(___) _____-_____**W**(___) _____-_____

Cell Phone: (___)_____**E-mail**_____

Contact Person:_____

Phone: W(___) _____-_____**H**(___) _____-_____

Gender Identity:_____**Assigned at Birth(if different):**_____

Preferred Pronouns:_____

Occupation:_____**Duration**_____

MD._____**Phone:**(____) _____-_____

Height:_____**Weight:**_____

Eye glasses/Contacts_____ **Cosmetic Surgery:**_____

Left/Right handed:_____

Children: _____**Pets:**_____

Referred by:_____

Present/Current Complaint:_____

_____

_____

_____

Pain, Where?_____

_____

_____

_____

History & Past Treatment & Old Injuries:_____

_____

Vaccinations/reactions to vaccinations:_____

_____

_____

What Specific Events Have Impacted or Changed Your Life:_____

_____

_____

_____

Medication Circle where appropriate put an * if you are on them today

Antibiotic	Cholesterol	Sleeping pills
Anti-inflammatory	Cortisone/steroid treatments	Thyroid
Antihistamines	Heart/Blood pressure	Vitamins
Antidepressant	Hormones	Cortisone/steroid treatments
Aspirin/Tylenol	Laxatives	
Chemotherapy/radiation	Oral Contraceptives	
Recreational Drugs Specify		

Duration _____ How often _____
Do you smoke_____ If yes how often_____
Do you drink alcohol _____ If yes how often _____

Do you have any side effects or complaints with your medication?_____

_____

_____

Additional therapies: Do you use Chiropractic, Acupuncture, herbal remedies, vitamins, etc…_____

_____

Have you had any major illnesses or surgeries? _____

_____

_____

Family History Please list all ailments: (e.g. Cancer, TB, Asthma, Heart disease) _____

_____

_____

_____

Sleep Patterns:_____

_____

_____

Personal History Circle where appropriate. Put * if you have this today

Acne	Fungal Infections	Nose Bleeds
Allergies	Gallbladder	Numbness
Anemia	Gonorrhea	Paralysis
Angina	Hayfever	Pneumonia
Arthritis	Heart Disease	Polio
Asthma	Hepatitis A/B/C	Rectal Problems
Boils	Herpes	Rheumatism
Candida	High/Low Blood Pressure	Sciatica
Carpal Tunnel	Hot/Cold Flashes	Sexual Dysfunction
Chlamydia	Infections	Skin Problems
Constipation	Kidney Problems	Syphilis
Dental Issues	Liver Dysfunction	TB
Diabetes 1	Low Libido	Tennis Elbow
Diabetes 2 (Insulin)	Meningitis	Tingling
Diarrhea	Mono	Ulcers
Excessive Eating	Night Sweat	Warts

Men(Circle where appropriate)

Premature Ejaculation	Discharge	Painful Testes
Seminal Emission	Painful	Warts
Impotence	Lumps	Pain when urinating
Prostate/Kidney	Rash	Itching
Swelling	Hernia	Erectile Dysfunction

Women(Circle where appropriate)

Menstrual

Painful	Early	Pregnancy
Absent	Irregular	Hysterectomy
Heavy	Cramps	Miscarriage
Light	Bearing down	C - Section
Clots	Abnormal bleeding	Bleeding between menses
Scanty	Menopause	PMS
Late	Abortions	

Vaginal

Discharge	Painful urinating	Warts
Dryness	Rash	
Yeast	Itching	

Breast

Lumps	Painful	Discharge
Swollen	Discoloration	Hard

EMOTIONS

Indicate with numbers: 1 being mildest -1 2 3 4 5- 5 being strongest
If it does not apply then leave blank

Affectionate	Grief	Righteous
Ambitious	Guilty	Sadness
Angry	Hold in Feelings	Secretive
Anxious	Hurried	Self-esteem
Assertive	Impatient	Self-pitying
Bossy	Independent	Sensitive
Cautious	Insecure	Sentimental
Closed	Jealous	Serious
Confidence	Lonely	Sexual
Courageous	Loss	Spiritual
Critical	Love music	Stubborn
Death	Loving	Suicidal
Depressed	Motivated	Suicidal thoughts
Discontented	Need company	Swearing
Disorganized	Needy	Talkative
Distrust	Non assertive	Tense
Dogmatic	Observant	Thrifty
Dullness	Optimistic	Tidy
Easily Hurt	Organized	Trouble concentrating
Excitable	Panic attacks	Unaffectionate
Fanatical	Pessimistic	Unemotional
Fastidious	Poor memory	Unforgiving
Fearful	Procrastinate	Uninterested
Flirtatious	Regretful	Violent
Forceful	Religious	Weepy
Forgetful	Resentful	Workaholic
Generous	Restless	Worried

Prefer outdoors/ indoors?	Favorite season?
Tolerate temperature change?	Favorite color?
Food desires?	Drinks desires?
Food aversions?	Drinks aversions?
Like solitude/company?	Like touch from others
Like attention when unwell?	Sleep position?

Hobbies/sports_____

Other Comments:_____

_____

_____

****

I,_____ State all information given above is to the best knowledge, all true and correct. I understand the homeopaths associated with Los Angeles School of Homeopathy are not state licensed. (There is no License in the State of California see SB577) ***To cancel or reschedule an appointment, please do so 5 days prior to the appointment or there is a charge.***

Signed _____ *Date*_____

LOS ANGELES HOMEOPATHIC CLINIC
ACKNOWLEDGMENT, CONSENT AND RELEASE WAIVER

Welcome to Los Angeles Homeopathic Clinic

The Los Angeles School of Homeopathy Clinic is a teaching Clinic. Our purpose is to provide excellent Homeopathic care to you, and a learning environment for student interns to gain knowledge and experience in the practice of Homeopathy. A Clinic supervisor will supervise our interns and oversee every Homeopathic consultation in the Clinic.

Due to the limited hours available to interns and supervisors, you may not be able to see the same intern or supervisor for every appointment, although we try to accommodate consistency throughout your Homeopathic care. The school has no availability for treatment in-between scheduled appointments. We can only address your issues while at your schedule appointment time.

To further the mission of Los Angeles School of Homeopathy, client Clinical records may be reviewed as needed by the faculty at the school. Results may be published in Homeopathic Journals to further the course of Homeopathic *care*. All personal information will remain confidential. You must submit a written request that your case not be included in any research publication.

1. I agree to be interviewed by a Los Angeles School of Homeopathy intern who will report to an on-site supervisor. I understand the interview may include questions about physical, emotional, mental and spiritual issues concerning myself. I understand the results of Homeopathic care are not guaranteed.

2. I am over the age of 18 years. I have read this document and am fully familiar with its contents. I have executed this document freely and voluntarily, and without any promises by Los Angeles School of Homeopathy, except those, if any, expressly contained in this document.

3. Payments: By signing below you agree to have your card on file and charged for any serviced rendered.

4. This document will be binding upon me, and I release any responsibility against, my heirs, executors, administrators, successors and assigns, and will ensure to the benefit of Los Angeles School of Homeopathy, and their heirs, executors, administrators, successors and assigns.

5. Agreement to Arbitrate: I agree to arbitrate any disputes as provided by California state law, and not by a lawsuit. By entering into this contract I am giving up the constitutional right to have any such dispute decided in a court of law before a jury. All claims must be arbitrated.

6. I understand and agree that I will be videoed and recorded, as other interns will view my case via video.

As a non-profit Clinic, we adhere to the following office policies:

a) Clients must inform us 5 days in advance of a cancellation/reschedule of an appointment or there is a charge for that missed appointment.
b) Please make the commitment to your first visit and at least two follow-up visits.
c) Most homeopathic remedies will need to be picked up by you at a local homeopathic pharmacy. The cost of a remedy is usually around $10.00 or less.
d) The fee is $85.00 for the first visit and $45.00 for the follow up visits. There is also a sliding scale if needed.
e) At the time of booking your initial appointment**,** a credit card will be necessary to hold your appointment. Your card will be charged at the time of your appointment and not before. You can also

pay via Venmo or Zelle, if arranged at the time of the appointment, payments are due at the time of service. If we ship you any remedies or order them on your behalf, we will charge you for those.

f) Credit card information: Patients will be responsible for updating the credit card on file as needed throughout treatment.

CALIFORNIA SENATE BILL SB-577 ~ WHAT IT MEANS FOR CLIENTS

California Senate Bill SB-577, which was signed by the governor in September 2002, has profound implications for the practice of alternative forms of health care in California. SB-577 enables alternative and complementary health care practitioners to provide and advertise their services legally. However, they must also comply with certain requirements specified within the bill.

What does Senate Bill SB-577 mean for you, the client?

SB-577 gives you access to alternative and complementary health care practitioners. You must be given informatio about the nature of treatment and the practitioner's qualifications. Feel free to ask a practitioner any question you might have about your treatment. Check to see if your practitioner has been certified by a professional membership society. In addition, tell your doctor about any alternative treatment you are pursuing. You can also request that your licensed and unlicensed health care providers communicate with each other and work collaboratively to meet your health care needs.

SB-577 helps to protect you. SB-577 requires unlicensed alternative health care practitioners to follow certain guidelin and restrictions.

Here are the things that unlicensed alternative practitioners are NOT allowed to do:

- Perform any form of surgery or any procedure that punctures your skin or harmfully invades your body.
- Use X-ray radiation.
- Prescribe prescription drugs, or recommending that you discontinue drugs that were prescribed by a licensed physician
- Set fractures.
- Treat wounds with electrotherapy.
- Put you at risk of great bodily harm, serious physical or mental illness, or death.
- Imply in any way that they are licensed physicians.

In addition, an unlicensed alternative practitioner MUST DO the following things:

- Provide you with a statement, written in plain language that includes the following information:
  (1) That they are not a licensed physician and that their services are not licensed by the state;
  (2) A brief and clear description of the kind of services they provide and the reasoning behind it;
  (3) A description of their education, training, and experience.

By signing below, I agree to the terms above.

Print Name:

Signature: Date: