

Helena Valley Chiropractic  
3b/160 Scott St  
Helena Valley WA 6056  
Western Australia

**9255 1052**

### Welcome Form - Homeopathy

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health, for years to come.*

Name \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email address \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

Whom to notify in case of emergency \_\_\_\_\_

Name of Medical Practitioner \_\_\_\_\_

Which private health fund are you currently with? \_\_\_\_\_

**REASON FOR THIS VISIT**

Your reason for *this* visit \_\_\_\_\_

Have you ever seen a **Homeopath**? Yes/No      If yes, when and why? \_\_\_\_\_

\_\_\_\_\_

Please describe your symptom/health concern as fully as possible \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did symptoms begin? \_\_\_\_\_ Have you had similar conditions in the past? \_\_\_\_\_

**PATIENT HEALTH HISTORY**

Please describe any past major emotional or psychological trauma \_\_\_\_\_

Please list any medication you are taking: \_\_\_\_\_

Please list and describe any *serious* injuries or surgical operations you have had in the *last 10 years*:

Falls \_\_\_\_\_ Head Injuries \_\_\_\_\_

Broken Bones \_\_\_\_\_ Dislocations \_\_\_\_\_

Operations \_\_\_\_\_

Other serious injuries \_\_\_\_\_

Are you pregnant? Yes/No    If so, how many weeks? \_\_\_\_    Are you breast feeding? Yes / No

**MEDICAL CONDITIONS** Of the following please tick those that apply to you:

- Heart attack/stroke     Shingles     Neck Pain     Headaches/migraines
- Heart defect     HIV positive     Jaw pain     Ear aches
- Emphysema     Diabetes     Shoulder pain     Ringing in ears
- Tuberculosis     Arthritis     Arm pain     Dizziness
- Fainting     Kidney problems     Wrist pain     Difficulty breathing
- Hepatitis     Colitis     Low back pain     Psychiatric problems
- Anaemia     Ulcers     Leg pain     Drug abuse
- Cancer     Artificial joints     Epilepsy

I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself / my child. I understand that Robin Clark is a homeopath and does not diagnose any disease or condition. I understand that the goal of homeopathy is to increase my / my child's general vitality and constitutional strength.

Signed..... Date.....

Print Name.....

*Any information you give to our clinic will always be held in the strictest confidence. At no time will any information you provide to us be shared, sold, disseminated, discussed or displayed without your express permission. The doctor/patient relationship will be adhered to in all circumstances.*