Tara Jensen, DSHM, BA

Adult Homeopathic Consultation Form

Name:_____ Date of Birth: D_____ M_____ Y_____

Address:_____

_____

Street City Postal code

Telephone: Home:_____ Work_____ Other_____

E-mail address:_____

Referred By:_____ Present M.D. and Phone no.:_____

Major Complaints in Order of Importance For You:

Complaint	Since	Causes

Which Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments or Regimes Are You Currently Following?

Treatment or Regime	Since	Results

Which Of The Following Conditions Have You Had?

Abscesses	Alcoholism	Allergies	Amnesia	Anemia	Asthma	Cancer
Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Emphysema	Epilepsy
Gall Stones	Goitre	Gonorrhea	Gout	Hay Fever	Heart Disease	Hepatitis
Herpes Genitalia		Influenza	Kidney Disease	Leukemia	Malaria	Measles
Miscarriage	Mononucleosis	Mumps	Parasites	Pelvic Inflammatory Disease		Peritonitis
Pleurisy	Pneumonia	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sun Stroke	Syphilis	Tonsillitis
Tuberculosis	Typhoid Fever	Venereal Warts	Warts	Whooping Cough	Worms	

Any Other Major Conditions?_____

Are there any of the preceding conditions after which you have not been totally well again? Which Ones?
_____

Age of first Menses:_____ Number of Pregnancies:_____

Are You Currently Under the Care of a Physician(s)?

Physician	For What Condition?	Treatments

What Major Operations Have You Had?

Operation	When	Complications

What Major Injuries Have You Had?

Injury	When	Complications

Vaccination History/Childhood Illness:

Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No

Any Adverse Effects from any of these Vaccinations?:
_____
_____

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 at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			

Paternal Grandfather			
Paternal Aunts/Uncles			

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

_____

_____

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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 Tara Jensen 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 Tara Jensen, 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 acknowledge that all personal information will be kept confidential.

Patient Signature:_____ Date:_____

Witness (for minors):_____