



FOUNDATION

Name (First Name and Last Initial ONLY) \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender M F Non-conforming Preferred pronouns \_\_\_\_\_

Occupation \_\_\_\_\_

How did you hear about AHE Student Clinic? \_\_\_\_\_

Primary Health Concerns

1) \_\_\_\_\_ 4) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_

Please check all that apply to you and list approximate dates.

<input type="checkbox"/> Acne	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Nightmares
<input type="checkbox"/> AIDS	<input type="checkbox"/> Fibroids (uterine)	<input type="checkbox"/> Overweight
<input type="checkbox"/> Alcohol/drug problem	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Panic Attack
<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pelvic Infection
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Periodontal Disease
<input type="checkbox"/> Antibiotics (1x a year)	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Premenstrual Tension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Hernia	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Blood clots	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> STI's
<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Hives	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Infection/stones	<input type="checkbox"/> Steroid Use
<input type="checkbox"/> Cataract (s)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemical Sensitivity	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Colitis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Neurological Problem	<input type="checkbox"/> Vaccine Reaction
<input type="checkbox"/> Eczema		<input type="checkbox"/> Warts

Personal Medical History

Current Prescription Medications (List prescribing doctor)	Date Started

<b>Vitamin/Mineral Supplements</b>	
<b>Surgery:</b> List all procedures and approximate dates	
<b>Hospitalizations:</b> Reasons/Dates	
<b>Accidents, Traumatic Injuries, Broken Bones:</b>	
<b>Allergies</b>	<b>Food Allergies</b>

<p>Have you used Homeopathy before?  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Have you worked with a Homeopath before?  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, when last seen: _____</p>	<p>List any homeopathic remedy or remedies you have taken within the past 2 months:</p>
<p>List other therapies or healing modalities (conventional or alternative) you have used to address your health concerns:</p>	

**Diet & Lifestyle**

<p><b>Food Cravings</b></p>	<p><b>Alcohol/Recreational Drug Use</b>  Do you drink alcohol or use drugs?   How much/often?</p>
<p><b>Caffeine</b>  Do you drink coffee or tea?   How much/often?</p>	<p><b>Cigarettes</b>  Do you smoke now or did you in the past?   How much/often?</p>
<p><b>Diet Soda/Artificial Sweeteners</b>  Describe your use:</p>	<p><b>Refined Sugars/Processed Foods:</b>  Describe your use:</p>

<p><b>Hobbies</b></p> <p>How often do you do them?</p>	<p><b>Living Situation</b></p>
--	--------------------------------

<p><b>Exercise:</b> Describe the ways you get your body moving. Do you feel you get enough physical activity?</p>	<p><b>Food:</b> Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support?</p>
---	---

<p><b>Worry/Anxiety:</b> Do you have particular issues that worry you? How does this impact your life?</p>	<p><b>Healthy Relationships:</b> Do you have a supportive family/community?</p>
--	---

<p><b>Unhealthy Relationships:</b> Have you been a victim of domestic abuse or troubling relationships?</p>	<p><b>Spiritual Life:</b> Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory?</p>
---	---

<p><b>Intimacy:</b> Are you satisfied with your sexual/intimate life?</p>	<p><b>Anything else?</b> Please indicate any topics you want to address in your consultation.</p>
---	---

**Hormonal Health (Check all that apply or answer as applicable)**

Male	Female	
<input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Decreased urine stream <input type="checkbox"/> Unable to interrupt stream <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Pus or drainage from penis <input type="checkbox"/> Genital swelling <input type="checkbox"/> Rash/eruptions <input type="checkbox"/> Problems with sexual function  Comments:	Date of last menstrual period _____ Length of cycle _____ Length of period _____ Age menstruation began _____ Menopause (list date) _____ Number of pregnancies _____ Number of live births _____ Number of abortions/miscarriages _____  Comments:	Check all that apply:  <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Spotting between periods <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Issues with fertility <input type="checkbox"/> Problems with sexual function

## Life Changes

In the past year, what changes have occurred in your:

<b>Personal Life:</b>
<b>Family Life:</b>
<b>Social Life:</b>
<b>Work Life:</b>
<b>Sex Life:</b>

## Family History

Age

If passed, cause of death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Children \_\_\_\_\_

Check all that apply to blood relatives, and list relationship.

<input type="checkbox"/> Alcohol/drug problem	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Allergy	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Obesity
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Suicide
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Epilepsy/seizure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Heart Disease	