Name (First Name and Last Initial ONLY) _____Date _____

Date of Birth _____ Age _____ Height _____Weight _____

Gender ☐M ☐F ☐Non-conforming Pronouns used _____

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.

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

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

Personal Medical History

Current Prescription Medications (List prescribing doctor)	Date Started

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

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

Diet & Lifestyle

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

Hobbies How often do you do them?	Living Situation

Exercise: Describe the ways you get your body moving. Do you feel you get enough physical activity?	**Food:** Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support?
Worry/Anxiety: Do you have particular issues that worry you? How does this impact your life?	**Healthy Relationships:** Do you have a supportive family/community?
Unhealthy Relationships: Have you been a victim of domestic abuse or troubling relationships?	**Spiritual Life:** Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory?
Intimacy: Are you satisfied with your sexual/intimate life?	**Anything else?** Please indicate any topics you want to address in your consultation.

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

Male	Female	
☐ Enlarged prostate ☐ Decreased urine stream ☐ Unable to interrupt stream ☐ Dribbling after urination ☐ Pus or drainage from penis ☐ Genital swelling ☐ Rash/eruptions ☐ 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: ☐ Vaginal discharge ☐ Spotting between periods ☐ Painful intercourse ☐ Issues with fertility ☐ Problems with sexual function

Life Changes

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

Personal Life:
Family Life:
Social Life:
Work Life:
Sex Life:

Family History

	Age	If passed, cause of death
Father		
Mother		
Siblings		
Children		

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

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