



SOBBEY'S  
HOMEOPATHIC  
CLINIC INC.

# PATIENT INTAKE FORM

## Medical and Health History

### Section One- Personal Information

Name (First and Last): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Their relation to you: \_\_\_\_\_

Please Circle:          Single          Married          Widowed          Co-habitant

Do you have any children: \_\_\_\_\_

### Section Two- Chief Concerns

Please fill out the following regarding your health concerns in order of importance as well as when these concerns began?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What medications are you currently taking?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other treatments/regimens are you currently following?



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What hospitalizations or surgeries have you had?

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## Section three-Medical and Health History

Which of the following conditions have **you** had?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abscesses      | <input type="checkbox"/> Hay fever             | <input type="checkbox"/> Prostatitis      |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rubella          |
| <input type="checkbox"/> Amnesia        | <input type="checkbox"/> Herpes Genitalia      | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Angina         | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Sciatica         |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sexual Abuse     |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High blood Pressure   | <input type="checkbox"/> Skin Disease     |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Influenza             | <input type="checkbox"/> Strep Throat     |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Kidney Stones         | <input type="checkbox"/> Sinusitis        |
| <input type="checkbox"/> Cold Sores     | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Small Pox        |
| <input type="checkbox"/> Colitis        | <input type="checkbox"/> Malaria               | <input type="checkbox"/> Sunstroke        |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Measles               | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Meningitis            | <input type="checkbox"/> Syphilis         |
| <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Mononucleosis         | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Neuritis or Neuralgia | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Gall Stones    | <input type="checkbox"/> Painful/Achy Joints   | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Gastritis      | <input type="checkbox"/> Pancreatitis          | <input type="checkbox"/> Venereal Warts   |
| <input type="checkbox"/> Goitre         | <input type="checkbox"/> Parasites             | <input type="checkbox"/> Warts            |
| <input type="checkbox"/> Gonorrhea      | <input type="checkbox"/> Pelvic Infl. Disease  | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Gout           | <input type="checkbox"/> Peritonitis           | <input type="checkbox"/> Yellow Fever     |



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## Family History

Please indicate below which of the following ailments have affected your **relatives**:

\_\_\_\_\_ Alcoholism

\_\_\_\_\_ Allergies

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Asthma

\_\_\_\_\_ Cancer

\_\_\_\_\_ Depression

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Gonorrhea

\_\_\_\_\_ Gout

\_\_\_\_\_ Hay Fever

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ Insanity

\_\_\_\_\_ Paralysis

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Skin Diseases

\_\_\_\_\_ Syphilis

\_\_\_\_\_ Tuberculosis