The highest ideal of cure is the rapid, gentle, and permanent restoration of health; the removal and annihilation of the whole disease by the shortest, most reliable, and least harmful way, according to clearly comprehensible principles.

Samuel Hahnemann, Organon, 6th edition

It was once said that "nature cures and homeopaths facilitate" and I believe this to be true. Homeopathy is a system of medicine that stimulates the body to heal itself. This is accomplished by addressing 'imbalances' in the body which lead the patient to their diseased state. In homeopathy, symptoms produced by an individual are not the disease but instead are an expression of the body's attempt at cure and as such can be used as guides for homeopathic healing, curing "like with like". After successful treatment, not only will the patient find themselves symptom free, with no side effects, they will also be healthier and more vital as a whole; because the body's own attempt to cure, in terms of symptoms produced, was honoured and not suppressed. It is a wonderfully unique and extremely effective means of healing. I welcome you to homeopathic medicine and my practice, here to serve you as its facilitator.

I have enclosed a medical intake form and fee schedule for you to read, complete and sign where appropriate, prior to our initial consultation. Please bring both of these forms with you at that time. I ask that you review what symptoms you wish to discuss. Include specifics as to what makes your symptom(s) individualized. To assist you in thinking about your symptoms in the homeopathic paradigm, please refer to the handout provided titled, "Reporting Symptoms Homeopathically". In general, the more information I can obtain regarding your illness, the more accurate I can be finding the appropriate homeopathic remedy.

Sincerely,

Sarah Pepper

GENERAL INFORMATION

Name:_____ Date of Birth: _____

Day/Month/Year

Address: _____

Street City Postal Code

Telephone: Home: _____ Work: _____ Other: _____

Email: _____

Present M.D.: _____ Phone no: _____

Referred by: _____

PATIENT INFORMATION

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

COMPLAINT SINCE CAUSES

_____

_____

_____

_____

WHAT MEDICATIONS IS YOUR CHILD CURRENTLY TAKING?

MEDICATION SINCE ADVERSE EFFECTS

_____

_____

_____

CIRCLE EACH OF THE FOLLOWING CONDITIONS YOUR CHILD HAS HAD:

- Abscesses
- AIDS/HIV
- Alcoholism
- Allergies
- Amnesia
- Anemia
- Anxiety Disorder
- Asthma
- Cancer
- Chicken Pox
- Cold Sores
- Colitis
- Depression
- Diabetes
- Eating Disorder
- Eczema
- 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
- Schizophrenia
- Schizoid-affected disorder
- Sexual Abuse
- Skin Disease
- Strep Throat
- Sinusitis
- Stroke
- Sun Stroke
- Syphilis
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Venereal Warts
- Warts
- Whooping Cough
- Worms
- Yellow Fever

ANY OTHER MAJOR CONDITIONS: _____

ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH YOUR CHILD HAS NEVER BEEN TOTALLY WELL AGAIN? WHICH ONES?

_____

_____

WHAT MAJOR INJURIES/OPERATOINS HAS YOUR CHILD HAD?

	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
Meningitis	Yes	No
Hepititis B	Yes	No
HPV	Yes	No

ANY OTHER VACCINATIONS? _____

ANY ADVERSE EFFECTS FROM ANY OF THESE VACCINATIONS?

_____

ANY OTHER VACCINATIONS?

_____

_____

HAS YOUR CHILD BEEN TREATED WITH HOMEOPATHY BEFORE?

HOMEOPATH WHEN? FOR WHAT CONDITIONS? REMEDIES

_____

_____

_____

HEALTH HISTORY OF RELATIVES

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS THAT HAVE AFFECTED YOUR RELATIVES:

- Alcoholism
- Allergies
- Arthritis
- Asthma
- Cancer
- Depression
- Diabetes
- Epilepsy
- Gonorrhoea
- Gout
- Heart Disease
- Mental illness (specify)
- Paralysis
- Pneumonia
- Skin Disease
- Syphilis
- Tuberculosis

ANY OTHER MAJOR AILMENTS? _____

	AGE IF ALIVE	AGE AT AND CAUSE OF DEATH	AILMENTS
MOTHER:			
FATHER:			
BROTHERS:			
SISTERS:			

CHILDREN: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

MATERNAL AUNTS/UNCLES: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

PREVIOUS PREGNANCIES OF NATURAL MOTHER, MISCARRIAGES OR COMPLICATIONS?

_____

_____

MOTHER'S AGE AT CHILD BIRTH: _____

MOTHER'S HEALTH DURING PREGNANCY: LIST ANY BLEEDING, NEUSEA, ILLNESS, PHYSICAL OR EMOTIONAL TRAUMA, HYPERTENSION, DIABETES, MEDICATIONS, ALCOHOL, DRUG, CIGERETTE CONSUMPTIONS, ETC.

_____

_____

_____

BIRTH HISTORY: FULL TERM _____ LATE _____ PREMATURE _____

BIRTH WEIGHT_____ LENGTH OF LABOUR _____ COMPLICATIONS _____

_____

DEVELOPMENT

AGE YOUR CHILD BEGAN: SITTING: _____ CRAWLING: _____ WALKING: _____

FIRST WORDS: _____

FEEDING: BREAST FED? _____ HOW LONG? _____ FORMULA? _____

AGE BEGAN SOLID FOODS: _____ FOOD INTOLERANCES? _____

IS THERE ANYTHING ELSE YOU FEEL IS IMPORTANT TO YOUR CASE?

_____

_____

_____

_____

MEDICAL/PROFESSIONAL WAIVER

PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.)

I, the undersigned, understand that Sarah Pepper is a homeopathic practitioner of classical homeopathy 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 Sarah Pepper, 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: _____

Reporting Symptoms Homeopathically

1. Describe, in detail, the onset of your symptoms. Outline any related mental, emotional or physical symptoms and/or any external condition(s) that may have contributed to your state of being at the time.
2. Outline all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these ailments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?
3. Describe any symptoms you are experiencing in terms of its location in the body. Does this symptoms shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptoms? How it feels/looks/smells/tastes? Anything that makes the symptoms unique, striking or unusual? If pain is involved, describe the pain you endure ex. dull ache compared to sharp, stabbing pain, a constant or periodic pain etc. Describe the onset of your pain; slow compared to sudden? How intense is the pain?
4. Write down when your symptoms feel better or worse: time of day/ when hot or cold/ month/ season/ before or after eating/ sleep/ moving/ resting/ certain positions/ when occupied/ specific mental emotional states.
5. Are you affected in any way by different kind of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by the sea shore.
6. Menses: Length of cycle/ length of period/ significant pain associated with menses/ length of period/ nature of flow/ clotting/ cramping/ PMS/ mood swings/ bloating/ swollen tender breasts/ cravings/ vaginal discharge with or without menses.
7. Sex: Desire/ aversion/ painful intercourse/ vaginal dryness/ impotency.
8. Perspiration: profuse/ scanty/ odour.
9. Body temperature: Hot vs. Cold body type/ hot or cold hands or feet or other body part/ hot flashes.
10. Sleep: Do you wake up at night? When? Why? How do you feel in the morning of rising? In what position do you sleep: side/ back/ front? Are parts of your body covered or exposed with sleep? Do you have recurring dreams in your sleep? Are there any prominent themes to your dreams? Night terrors?
11. What motivates you in life? Are there lasting traits from childhood that still an issue today? Are there running themes in your life? All my life I've been...". How would others describe you? How do you deal with change in your life? Do you need structure in your life?

Please elaborate on any of the above if applicable.
