

**Personal Health Questionnaire**

*All information will remain strictly confidential. Homeopathy helps balance the whole person on a physical, emotional and mental level. Please be as open and precise as you can. If your child is old enough have, him/her fill out the questionnaire or help them through it. For babies do the best you can and use your intuition, you know your child best.*

Thank you for your trust and patience.

Please print clearly

**Date:**

**Name:**

**DOB:** M/D/Y

**Age:**

**Place of Birth:**

**Address:**

**Phone:** H( )

**E-mail:**

**Mother's name:**

**Cell Phone:** ( )

**W( )**

**Father's Name:**

**Cell Phone:** ( )

**W( )**

**Grade in School:**

**Pediatrician:**

**Phone:** ( )

**Height:**

**Weight:**

**Gender Identity:**

**Assigned at Birth:**

**Preferred Pronouns:**

**Surgery:**

**Left/Right handed:**

**Siblings:**

**Pets:**

**Referred by:**

**Present/Current Complaint:**

**Pain, Where?**

**History & Past Treatment & Old Injuries:**

## Vaccinations

	Birth	1 M	2 M	4 M	6 M	12 M	15 M	19-23 M	2-3 Y	4-6 Y	7-10 Y	11-12 Y	13-18 Y
Vitamin K (At birth)													
Silver Nitrate drops (At birth)													
Hepatitis B (At birth on going series)													
Rotavirus (2, 4, or 6 months)													
Diphtheria, Tetanus, Pertussis DTAP (2,4,6 Months, 11, 13 Years)													
Pneumococcal (PCV) (2,4,6 months)													
Polio (IPV) (2,6, Months & 6-18 Month range)													
Influenza (usually yearly)													
Measles, Mumps, Rubella MMR (12-15 Months, 4-6 Years)													
Haemophilus influenza type b Hib (2,4,6 months)													
Varicella (chickenpox) (12-15 months & 4-6 years)													
Hepatitis A (12-18 months, ongoing, series)													
Meningococcal MCV4 (3-6 years, 11 years)													
Human Papillomavirus HPV (3 doses- 11-13 Years)													

### Reactions to Vaccines:

### What Specific Events Have Impacted or Changed Your Life:

**Family History** Please list all ailments: (e.g. Cancer, TB, Asthma, Heart disease)

**Personal History** Circle where appropriate. Put \* if you have this today

Accidents	Diabetes 1 (Diet)	Hepatitis	Night sweats
Addictions	Diabetes 2 (Insulin)	Herpes	Nose bleeds
ADD/ADHD	Drug overdose	High/Low blood pressure	Numbness
Alcoholism	Drug problem	HIV/AIDS	Panic attacks
Allergies	Dyslexia	Infections	Paranoia
Anemia	Endometriosis	Insomnia	Paralysis
Angina	Epilepsy	Jaundice	Physical abuse
Anorexia	Excessive eating	Kidney dysfunction	Pneumonia
Anxiety	Excessive fears	Liver dysfunction	Polio
Asthma	Flashes (hot/cold)	Low Libido	Rectal problems
Bi-Polar	Food poisoning	Manic depression	Ringling in ears
Boils	Fungus	Meningitis	Sexual abuse
Bulimia	Gall bladder	Mental disorder	Skin problems
Candida	Hay fever	Mono	Tingling
Chronic fatigue	Head injuries	Nervous	Ulcers
Convulsions	Headaches	Nightmares	Verbal abuse
Depression	Heart disease		Vertigo
			Warts

**Medication** Circle where appropriate put an \* if you are on them today

Anti-biotic	Heart	Radiation
Anti-inflammatory	Herbs	Relaxants
Anti-histamines	Laxatives	Sleeping pills
Antidepressant	Lithium	Street Drugs
Aspirin/Tylenol	Oral Contraceptives	Supplements
Chemotherapy	Thyroid	Vitamins
Cortisone	Over The Counter	
Other		
Duration		How often

What age did your child walk:

What age did your child talk:

What age did the fontanelles close?

**Mother Only**

How many Pregnancies?

Number of births?

Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs?

Specify

Abnormal bleeding during pregnancy?

Miscarriage:

C-Section:

Complications during Pregnancy?

Which Pregnancy?

Complications during Labor?

Which Labor?

How much alcohol do you drink?

Do you take medication?

What were your emotions at time of conception?

What were your emotions during the pregnancy?

**Father Only**

Time of Conception were you on any OTC, RX, Herbs, alcohol, drugs?

Specify

What were your emotions at time of conception?

What were your emotions during the pregnancy?

Did you have any complications during your wife's pregnancy?

How much alcohol do you drink?

Do you take medication?

**EMOTIONS** To the best of your ability help your child fill this page out, with infants go with your instinct. Indicate with numbers: 1 being mildest -1 2 3 4 5- 5 being strongest If it does not apply then leave blank

- |              |                  |                       |
|--------------|------------------|-----------------------|
| Affectionate | Grief            | Righteous             |
| Ambitious    | Guilty           | Sadness               |
| Angry        | Hold in Feelings | Secretive             |
| Anxious      | Hurried          | Self-esteem           |
| Assertive    | Impatient        | Self-pitying          |
| Bossy        | Independent      | Sensitive             |
| Cautious     | Insecure         | Sentimental           |
| Closed       | Jealous          | Serious               |
| Confidence   | Lonely           | Sexual                |
| Courageous   | Loss             | Spiritual             |
| Critical     | Love Music       | Stubborn              |
| Death        | Loving           | Suicidal              |
| Depressed    | Motivated        | Suicidal thoughts     |
| Discontented | Need company     | Swearing              |
| Disorganized | Needy            | Talkative             |
| Distrust     | Non assertive    | Tense                 |
| Dogmatic     | Observant        | Thrifty               |
| Dullness     | Optimistic       | Tidy                  |
| Easily Hurt  | Organized        | Trouble concentrating |
| Excitable    | Panic attacks    | Unaffectionate        |
| Fanatical    | Pessimistic      | Unemotional           |
| Fastidious   | Poor memory      | Unforgiving           |
| Fearful      | Procrastinate    | Uninterested          |
| Flirtatious  | Regretful        | Violent               |
| Forceful     | Religious        | Weepy                 |
| Forgetful    | Resentful        | Workaholic            |
| Generous     | Restless         | Worried               |

- Prefer outdoors/ indoors?
- Tolerate temperature change?
- Food desires?
- Food aversions?
- Like solitude/company?
- Like attention when unwell?

- Favorite season?
- Favorite color?
- Drinks desires?
- Drinks aversions?
- Like touch from others
- Sleep position?

Hobbies/sports

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I, \_\_\_\_\_ State all information given above is to the best knowledge, all true and correct. I understand the homeopathic intern is not state licensed. (There is no License in the State of California) Signed by parent or guardian. **To cancel or reschedule an appointment, please do so 5 days prior to the appointment or there is a charge.**

Signed

Date

**LOS ANGELES HOMEOPATHIC CLINIC**  
**ACKNOWLEDGMENT, CONSENT AND RELEASE WAIVER**

Welcome to Los Angeles Homeopathic Clinic

The Los Angeles School of Homeopathy Clinic is a teaching Clinic. Our purpose is to provide excellent Homeopathic care to you, and a learning environment for student interns to gain knowledge and experience in the practice of Homeopathy. A Clinic supervisor will supervise our interns and oversee every Homeopathic consultation in the Clinic.

Due to the limited hours available to interns and supervisors, you may not be able to see the same intern or supervisor for every appointment, although we try to accommodate consistency throughout your Homeopathic care. The school has no availability for treatment in-between scheduled appointments. We can only address your issues while at your schedule appointment time.

To further the mission of Los Angeles School of Homeopathy, client Clinical records may be reviewed as needed by the faculty at the school. Results may be published in Homeopathic Journals to further the course of Homeopathic care. All personal information will remain confidential. You must submit a written request that your case not be included in any research publication.

1. I agree to be interviewed by a Los Angeles School of Homeopathy intern who will report to an on-site supervisor. I understand the interview may include questions about physical, emotional, mental and spiritual issues concerning myself. I understand the results of Homeopathic care are not guaranteed.
2. I am over the age of 18 years. I have read this document and am fully familiar with its contents. I have executed this document freely and voluntarily, and without any promises by Los Angeles School of Homeopathy, except those, if any, expressly contained in this document.
3. Payments: By signing below you agree to have your card on file and charged for any serviced rendered.
4. This document will be binding upon me, and I release any responsibility against, my heirs, executors, administrators, successors and assigns, and will ensure to the benefit of Los Angeles School of Homeopathy, and their heirs, executors, administrators, successors and assigns.
5. Agreement to Arbitrate: I agree to arbitrate any disputes as provided by California state law, and not by a lawsuit. By entering into this contract I am giving up the constitutional right to have any such dispute decided in a court of law before a jury. All claims must be arbitrated.
6. I understand and agree that I will be videoed and recorded, as other interns will view my case via video.

**As a non-profit Clinic, we adhere to the following office policies:**

- a) Clients must inform us 5 days in advance of a cancellation/reschedule of an appointment or there is a charge for that missed appointment.
- b) Please make the commitment to your first visit and at least two follow-up visits.
- c) Most homeopathic remedies will need to be picked up by you at a local homeopathic pharmacy. The cost of a remedy is usually around \$10.00 or less.
- d) The fee is \$45.00 for the first visit and \$25.00 for the follow up visits. There is also a sliding scale if needed.
- e) At the time of booking your initial appointment, a credit card will be necessary to hold your appointment. Your card will be charged at the time of your appointment and not before. You can also pay via Venmo or Zelle, if arranged at the time of the appointment, payments are due at the time of service. If we ship you any remedies or order them on your behalf, we will charge you for those.
- f) Credit card information: Patients will be responsible for updating the credit card on file as needed throughout treatment.

## CALIFORNIA SENATE BILL SB-577 ~ WHAT IT MEANS FOR CLIENTS

California Senate Bill SB-577, which was signed by the governor in September 2002, has profound implications for the practice of alternative forms of health care in California. SB-577 enables alternative and complementary health care practitioners to provide and advertise their services legally. However, they must also comply with certain requirements specified within the bill.

### What does Senate Bill SB-577 mean for you, the client?

**SB-577 gives you access to alternative and complementary health care practitioners.** You must be given information about the nature of treatment and the practitioner's qualifications. Feel free to ask a practitioner any question you might have about your treatment. Check to see if your practitioner has been certified by a professional membership society. In addition, tell your doctor about any alternative treatment you are pursuing. You can also request that your licensed and unlicensed health care providers communicate with each other and work collaboratively to meet your health care needs.

**SB-577 helps to protect you.** SB-577 requires unlicensed alternative health care practitioners to follow certain guidelines and restrictions.

Here are the things that unlicensed alternative practitioners are NOT allowed to do:

- Perform any form of surgery or any procedure that punctures your skin or harmfully invades your body.
- Use X-ray radiation.
- Prescribe prescription drugs, or recommending that you discontinue drugs that were prescribed by a licensed physician.
- Set fractures.
- Treat wounds with electrotherapy.
- Put you at risk of great bodily harm, serious physical or mental illness, or death.
- Imply in any way that they are licensed physicians.

In addition, an unlicensed alternative practitioner MUST DO the following things:

- Provide you with a statement, written in plain language that includes the following information:
    - (1) That they are not a licensed physician and that their services are not licensed by the state;
    - (2) A brief and clear description of the kind of services they provide and the reasoning behind it;
    - (3) A description of their education, training, and experience.
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By signing below, I agree to the terms above.

Print Name:

Signature:

Date: