

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 Mark x 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	Numbness
Alcoholism	Drug problem	pressure	Panic attacks
Allergies	Dyslexia	HIV/AIDS	Paranoia
Anemia	Endometriosis	Infections	Paralysis
Angina	Epilepsy	Insomnia	Physical abuse
Anorexia	Excessive eating	Jaundice	Pneumonia
Anxiety	Excessive fears	Kidney dysfunction	Polio
Asthma	Flashes (hot/cold)	Liver dysfunction	Rectal problems
Bi-Polar	Food poisoning	Low Libido	Ringing in ears
Boils	Fungus	Manic depression	Sexual abuse
Bulimia	Gall bladder	Meningitis	Skin problems
Candida	Hay fever	Mental disorder	Tingling
Chronic fatigue	Head injuries	Mono	Ulcers
Convulsions	Headaches	Nervous	Verbal abuse
Depression	Heart disease	Nightmares	Vertigo
			Warts

Medication Mark x 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 _____
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What age did your child walk: _____

What age did your child talk: _____

What age did the fontanel 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?	_____	Favorite season?	_____
Tolerate temperature change?	_____	Favorite color?	_____
Food desires?	_____	Drinks desires?	_____
Food aversions?	_____	Drinks aversions?	_____
Like solitude/company?	_____	Like touch from others	_____
Like attention when unwell?	_____	Sleep position?	_____

Hobbies/sports_____

*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.....

ADAMAS HOMEOPATHIC CLINIC
ACKNOWLEDGMENT, CONSENT AND RELEASE WAIVER

Welcome to Adamas Homeopathic Clinic

The Adamas 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 the Adamas School of Homeopathy, client Clinical records maybe 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 an Adamas 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 Adamas 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 Adamas 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 \$85.00 for the first visit and \$45.00 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 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: _____