New Client Registration Form Today's Date_____

Name_____Birthdate_____Age___

Mailing Address_____

City_____State_____Zip_____

Contact Phone Numbers_____(primary)

Email Address_____

Name/phone# of primary care physician_____

Would you like me to communicate with your primary care physician from time to time? Y N

Conditions for which you are seeking assistance (please be specific):

Medications you are currently taking (include prescription, over the counter, recreational, herbs and supplements please):

Have you used homeopathy before? If so, who was your practitioner? Remedies taken? Results?

Please provide a brief health history. Note all major illnesses, hospitalizations, surgeries, skin conditions, major life or health events which were turning points in your life and your age at the time these events occurred.

Family health history. Note illnesses or health problems in all blood-related family members, along with cause of death for those who have passed away. Include grandparents, parents, siblings and children.

Please note any questions or concerns you would like to discuss as we begin.

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