



Blackmore Wellness

HOMEOPATHY

Mary Paterson Blackmore, DCHM (Hons) | *Registered Homeopath* | (613) 777-8869 - Consultation Form

Patient Information		For Office Use Only				
Name:			Name	Potency	Dose	Date
Address:		Initial Rx				
Phone:		1st Follow Up Rx				
Email Address:		2nd Follow Up Rx				
Date of Birth YYYY/MM/DD		3rd Follow Up Rx				
Referred by:						
Current M.D. (name/phone)						

Major Complaints in Order of Importance For You:

Complaint	Since	Causes

Which Medications Are You Currently Taking?

Medication	Since	Adverse Effects

What Other Treatments Are You Currently Following?

Treatment	Since	Results

Which Of The Following Conditions Have You Ever Had? (Please circle)

- | | | | | | | |
|--------------|------------------|----------------|-----------------|-----------------------------|---------------|---------------|
| Abscesses | AIDS/HIV | Alcoholism | Allergies | Amnesia | Anemia | Asthma |
| Cancer | Chicken Pox | Cold Sores | Colitis | Depression | Diabetes | Emphysema |
| Epilepsy | Gall Stones | Goitre | Gonorrhoea | Gout | Hay Fever | Heart Disease |
| Hepatitis | Herpes Genitalia | Influenza | Kidney Disease | Leukemia | Malaria | Measles |
| Miscarriage | Mononucleosis | Mumps | Parasites | Pelvic Inflammatory Disease | Syphilis | Peritonitis |
| Pleurisy | Pneumonia | Prostatitis | Rheumatic Fever | Rubella | Scarlet Fever | 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 Not Listed? _____

Are there any of the preceding conditions after which you have not been totally well again? Please identify which ones.

Age of first Menses: _____ Number of Pregnancies: _____

Are You Currently Under the Care of a Physician(s)?

Physician	For What Condition?	Treatments
_____	_____	_____
_____	_____	_____

What Major Operations Have You Had?

Operation	Month/Year	Complications

What Major Injuries Have You Had?

Injury	Month/Year	Complications

Vaccination History/Childhood Illness: (Please circle)

Measles	Yes	No
Mumps	Yes	No
Rubella/German Measles	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No

Any Adverse Effects from any of these Vaccinations?

How Much of the Following Substances Do You Use?

Tobacco _____ Alcohol _____ Coffee _____ Recreational Drugs _____

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Insanity	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis				

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

Is there any other information that I would need to know?

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Mary Blackmore is a homeopath 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 Mary Blackmore, 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 agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential.

Patient Signature: _____ Date: _____

Witness Signature: _____