

Negar Bahbahani-Ferdowsi – DSHom.Med. I.I.R.

Homeopathic Physician, Holistic Counsellor and Certified Reflexologist

Homeopathic Consultation – Confidential Health History

General Information

Name: _____

Address: _____

Home phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Email(optional): _____

Major Complaints in Order of Importance To You

If possible, please list the cause and length of time you have been affected by each complaint:

Are you currently under the care of a physician? _____

If yes, are you being treated for any conditions in particular?

Are you currently taking any medication? If yes, please

specify: _____

Have you noticed any adverse effects from these

medications? _____

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Are you currently under any other type of treatment? _____

Have you ever experienced any adverse effects from a vaccination? _____

Have you ever had any type of surgery? _____

Were there any complications? _____

Have you ever had any of the following conditions? Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes Genitalia | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> HIV | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Sexual Assault/Abuse |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Malaria | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Menopause | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Ear/ Hearing Issues | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraines | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Parasites | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Goitre | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Intestinal Worms |
| <input type="checkbox"/> Gonorrhoea | | <input type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> Gout | | |

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Are there any of the preceding conditions from which you have never fully recovered?:

Do you exercise on a regular basis? If yes, please specify:

Have you experienced any significant weight loss or gain recently? If yes, please specify:

Do you consume any of the following substances? If yes, please indicate how much and how often:

Coffee _____

Alcohol _____

Tobacco _____

Recreational Drugs _____

Health History of Relatives

Please check any of the following conditions present in your family:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Tuberculosis |

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If there are any other conditions present in your family please indicate them below for each relative as well as their current age. If the relative is deceased, please indicate their age at the time of death and the cause:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

Maternal Grandmother:

Maternal Grandfather:

Maternal Aunts/Uncles:

Paternal Grandmother:

Paternal Grandfather:

Paternal Aunts/Uncles:

What is your current understanding of Homeopathy?: _____

Have you ever been treated with Homeopathy before? If yes, please specify how long you were under care and for what reason(s): _____

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Are you currently taking any vitamin, mineral or herbal supplements? If yes, please specify: _____

Is there any other information that you feel is important to your case? Do you have any questions/concerns?: _____

Thank you for taking the time to complete this form.

All information contained herein will remain strictly confidential.

INFORMED CONSENT TO HOMEOPATHIC CONSULTATION AND TREATMENT

I, _____, understand that Negar Bahbahani-Ferdowsi is a Classical Homeopath, Certified Reflexologist and Holistic Counsellor 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. I understand that I will never be asked by Negar Bahbahani-Ferdowsi to discontinue or refrain from taking prescription medication. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay \$175.00 for my initial visit, \$65.00 for every following visit and \$15.00 for each remedy I am given(GST where applicable). I also agree to give at least 24 hours notice when cancelling my appointment. If I miss my appointment I agree to pay the missed appointment fee of 30 dollars.

I acknowledge that the state of my health is my own responsibility and in choosing homeopathy I am exercising my right to choose an alternative method of treatment that addresses my health in its entirety.

I have read the above consent and have had the opportunity to ask any questions I might have.

*If you are less than 18 years of age a parent or guardian must sign on your behalf.

Please print your name

Please sign your name

Date

Witness Signature

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