



Are there any of the preceding conditions after which you have not been totally well since?

Which ones? \_\_\_\_\_

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

Physician	For Which Condition?	Treatments
_____	_____	_____
_____	_____	_____

What Major Operations Have You Had?

Operation	When	Complications

What Major Injuries Have You Had?

Injury	When	Complications

Vaccinations: Covid-19, Flu, other

Vaccine	Doses	Side-effects

How Much of the Following Substances Are You Using?

Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_

Have you been treated by Homeopathy before? Which condition? Remedies taken?

\_\_\_\_\_  
\_\_\_\_\_

Any serious Shock, Grief, Disappointment, Fright, Depression etc?

\_\_\_\_\_  
\_\_\_\_\_

Food Intolerances?

\_\_\_\_\_  
\_\_\_\_\_

(Women)Age of first Menses: \_\_\_\_\_ (Women)Number of Pregnancies: \_\_\_\_\_

Are you taking any contraceptives, currently or previously? Y N

Which Ones? \_\_\_\_\_

For how long?

Starting at what age? \_\_\_\_\_

**Pregnancy of Mother and Delivery History**

**Mother’s Health during Pregnancy with you?** List any bleeding, nausea, illness, physical or emotional trauma, hypertension, diabetes, medications, alcohol, drug, cigarette consumption, antibiotics, vaccinations, etc. --

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**Conception:** previous miscarriages? planned baby? eldest child? IVF? emotional trauma?

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**Delivery?** Natural, c-section, anesthesia, epidural, induced, Rhesus injection, position of baby, placenta position

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**Birth History (Tick):** Full Term \_\_\_\_\_ Premature: \_\_\_\_\_ Late: \_\_\_\_\_

**Length of Labour:** \_\_\_\_\_ **Complications:** \_\_\_\_\_

**Birth: weight** \_\_\_\_\_ **height/length** \_\_\_\_\_

**Which of the following ailments, or any other major ailments, have affected your relatives:**

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhoea	Gout	Heart Disease	Mental Illness	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis	Addiction			

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

**Medical History Timeline**

Year/Age	Description (Diseases)	Medication/Treatment/Operations

Is there any other information that I need to know?

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**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 Miran Farah is a homeopathic practitioner of classical homeopathy 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 Miran Farah, I am exercising my right to choose an alternative method of treatment through which to address my total health. As The Homeopathy Healer does not accept any 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. I consent that from time to time I may receive e-mails from Miran Farah and/or The Homeopathy Healer which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_



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