Medical History for Consultation with Angie Litvinoff, Healer / Homoeopath

Please complete and bring with you to your initial consultation – in as much detail as possible

Date: _____(of initial consultation)

Name: _____ Age: ____ Date of birth: _____ Gender: M F

Address: _____ Town: _____ Postal Code: _____

Home phone: _____ Work or Other phone: _____

E-mail address: _____

GP details, Name and Address of Surgery:

Pls Circle one
Live with: • Spouse • Partner • Parents • Children • Friends • Alone

How did you hear about this practitioner? _____

CURRENT HEALTH CONDITION

What health concerns brought you here today? Please list in order of importance to you:
1. _____
2. _____
3. _____
4. _____

Has anything recently changed or become worse? _____
_____

Please list the five most significant stressful events in your life. Do any of these continue to affect you?
1. _____
2. _____
3. _____
4. _____
5. _____2

HEALTH HABITS
Height: _____ Current weight: _____ Weight 1 year ago: _____ Maximum weight: _____ when? _____

Smoker: • Yes • No Smoked _____ years Amount/day:_____ Year stopped: _____

Alcohol use: • Yes • No Type: _____ Frequency: _____

Recreational drug use: • Yes • No Type: _____ Frequency: _____

Coffee: • Yes • No _____ cups / day Tea: • Yes • No _____ cups / day

Water: _____ cups / day Purified water: • Yes • No Tap water: • Yes • No

Are there any food groups that you avoid? • Yes • No _____

Are there any food groups that you eat a lot of? • Yes • No _____

Do you eat dairy products? • Yes • No _____

On a scale of 1 to 10, with 10 being the highest, please rate your average STRESS level: _____

On a scale of 1 to 10, with 10 being the highest, please rate your average ENERGY level: _____

How many hours of sleep do you get a night? _____ Do you wake up feeling rested? • Yes • No

Regular exercise? • Yes • No Type: _____ Duration: _____ Frequency: _____

Women: Are you currently pregnant? • Yes • No • Not sure

Type of birth control used: _____ If birth control pill use, how many years? _____

MEDICAL HISTORY – Please tick the conditions that pertain to you personally:

- Alcohol Abuse
- Allergies
- Anemia
- Arthritis
- Asthma
- Bladder / Urinary Problems
- Bleeding Problems
- Blood Pressure Problems / Stroke
- Cancer
- Colitis
- Frequent colds, flu, sore throats
- Diabetes
- Digestive Disturbances
- Ear Problems
- Eating Disorders
- Edema
- Epilepsy
- Eye Problems
- Fatigue, Chronic
- Female Gynecological Problems
- Mononucleosis
- Fever
- Gall Bladder / Liver Problems
- Gum / Teeth Problems
- Hay Fever
- Headaches
- Head Injury / Serious Injury
- Heart Disorders
- Hepatitis
- Hypoglycemia
- Jaundice
- Joint Problems
- Kidney Problems
- Lung Problems
- Occupational Exposure to Toxic Substances
- Parasites
- Psychological Difficulties / suicidal / depression
- Sexually Transmitted Diseases (herpes, chlamydia, gonorrhea)
- Skin Problems
- Thyroid
- Ulcer

Please indicate any serious injuries or hospitalizations; along with approximate dates in chronological order:

_____

_____

Do you have any allergies? _____

_____

Please list all drugs and medications which you are currently prescribed, the reason and the effect and any recreational drugs, when taken and for how long:

_____

_____

Which medications have you used in the past, the reason and the effect? In chronological order

_____

_____

If you take supplements please list brands and dosages of all products you are taking and the reasons for taking them: _____

_____

_____

FAMILY HISTORY – Has a close relative (parent, child, sibling, grandparent) had any of the following:

Who? Mother, Father or Sibling (s) please circle

		Bleeding problems	M, F, S	Cancer	M, F, S
Allergies	M, F, S	Heart disease	M, F, S	Thyroid problems	M, F, S
Depression	M, F, S	Multiple sclerosis	M, F, S	Diabetes	M, F, S
Arthritis	M, F, S	High blood pressure	M, F, S	Emotionally related	M, F, S
Asthma	M, F, S	Kidney disease	M, F, S	Mental health issues	M, F, S
Drug use	M, F, S	Stroke	M, F, S	Other	M, F, S
Alcohol	M, F, S	Tuberculosis	M, F, S		
Epilepsy	M, F, S				

ENVIRONMENT
Are you regularly exposed to toxins or other hazards (home, work, hobbies, etc.)? Please describe:
_____

How would you describe the emotional climate of your home?
_____
_____

HEALTH HISTORY

Were you breast fed and for how long? _____

What was your health as a child until age 14? _____

_____

Did you have any other childhood diseases other than chicken pox, measles, and mumps?
_____

Please list all surgeries you have had, dates and reasons, and if you felt they were successful.
_____

Have you ever had travel or routine vaccinations and if so when? _____

What do you feel your weakest organ system is? _____

How many times each year do you get a cold, flu or bronchitis? How many days are you sick with it? Do you miss work because of it? _____

How many times have you had antibiotics in your life? _____

Has there been a trauma or sickness that you have never recovered from and you have not been well since?
_____
_____

FAMILY HISTORY
Please write down details of the health of your parents, siblings and children as appropriate:

Parents

Siblings

Children (ages and number of children)

WORK AND SOCIAL HISTORY
Work history details:

What you enjoy and like to do:

HEALTH GOALS
Please list your health goals in order of importance to you:
1. _____
2. _____
3. _____
4. _____

REGNANCIES, Births, Miscarriages, Abortions : please give details

PERIODS/ MENSTRUAL CYCLE: please give details including:
Infrequent bleeding
Too often bleeding
Thin blood
Thick blood
Clotting

Life History, please also indicate your character growing up, personality and a description of what your interests are as well as occupations, studies, travel or interests

Please outline significant events in your life, particularly the fist 14 years:

Ages 0-7

Ages 7-14

Ages 14-21

Ages 21-28

Ages 28-35

Ages 35-42

Ages 42-49

Ages 49-56

Ages 56-63

Ages 63-70

Ages 70 – 77

Ages 77+

ANYTHING ELSE

Any other information you would like me to know:

Your Statement

I understand that this information is confidential and may be referred to during my sessions, and that these sessions involve Healing, Shamanic Healing, Homoepathy, Essences and Meditation.

Name:

Signed:

Date:

For Angie to fill in: Additional Notes:

Tongue diagnosis

Examination findings

Chief complaint

General symptoms

SRP

Ph

Case analysis

Miasmatic diagnosis/ 5 Elements