The Center for Family Wellness

Theresa M. Bayer, Homeopathic Practitioner

Welcome to our office. Please complete all of the following questions.

Homeopathy Personal Profile Form

Patient Name: _____ **Date of Birth**:_____

Address:_____**City**:_____**State**: _____ **Zip**:_____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**:_____

Email: _____ **Who can we thank for referring you?** _____

Marital Status: □Single □ Married □ Divorced **Number of Children**: _____

Major Complaints: (Why did you come to our office?) ***Use back if additional space is needed.***

_____

_____

_____

When did these complaints first begin? _____

Have you had prior treatment for these complaints? □Yes □No **Date(s) of treatment**?_____

_____

In your opinion, what do you believe is the cause of your complaints? _____

_____

Were there any significant events (of any kind) which correspond with the onset of your complaints?

_____

Other complaints you would be interested in getting help for? _____

Please list any medications (prescription & over the counter) you are currently taking & why:

_____

_____

List any nutritional supplements, vitamins or herbs you are currently taking and why:

_____

_____

Have you had chiropractic treatment before: □ Yes □ No **If yes, how long and by whom**:_____

Do you regularly see a medical doctor: □ Yes □ No **If so, whom**: _____

Please list anything that causes stress in your life: _____

_____

List any emotional traumas you still have difficulty with (use back side if needed): _____

_____

Do you exercise regularly? □ Yes □ No **How much water do you drink a day?** _____

Please check if you have problems in any of these areas:

□ Numbness or swelling	□ Constipation/ Diarrhea	□ Reoccurring Sickness	□ Alcohol Use
□ Dizziness or light headiness	□ Urinary problems	□ Stomach/ Digestion problems	□ Recreational Drug Use
□ Fatigue or irritability	□ Sexual problems	□ Depression	□ Skin Problems
□ Ear Problems	□ Female problems	□ Allergies	□ Any Other_____
□ How or Low blood Pressure	□ Sinus problems	□ Tobacco Use	

*I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Payment is expected at the time of service unless definite financial arrangements are made in advance.

* I understand that I am responsible for giving 24 hours' notice to cancel or reschedule my appointment. If not, payment will be expected for the missed appointment.

Patient Signature: _____ Date: _____