

Active Homeopathy, LLC

American Medical College of Homeopathy – 1951 West Camelback Road, Suite 300; Phoenix, Arizona 85015
 Phone: 602-953-2469; email: myhomeopath@activehomeopathy.com; web: www.activehomeopathy.com

Registration Form - (Please print)

Name: _____ Birth date: _____
 Height: _____ Weight: _____
 Home Address: _____ Home Phone: _____
 City, State, Zip: _____ Email: _____

Gender		Marital Status				# of children
Male	Female	Single	Married	Divorced	Widowed	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Occupation						
Student	Homemaker	Retired	Unemployed	Disabled	Self Employed	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer: _____ Business/Work Address: _____
 City, State, Zip: _____ Work Phone: () _____

Person to be contacted in case of emergency: _____ Phone #: () _____
 Address: _____

Please indicate briefly the main problem for consulting a homeopath: _____

Please provide the following information starting with the most recent. Include type of illness, month and year hospitalized, name of hospital, city and state.

1. _____
2. _____
3. _____

Please list any medication you are taking (type, dosage, frequency ...) _____

Medicinal Herbs, Vitamins, Teas: _____

Do you use...?	Yes	No	Amount
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other drugs:	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____

Allergies: _____

Medical Tests	Year	Immunizations	Year
Chest X-ray	_____	Small Pox	_____
Electrocardiogram	_____	Tetanus	_____
TB Test	_____	Polio	_____
GI Series	_____	Typhoid	_____
Kidney X-ray	_____	Mumps, Measles	_____
Barium Enema	_____	Flu	_____
Other X-ray	_____	Other	_____

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Registration Form continued (Please Print)

What are you most sensitive to (example: Noise, odors, light, pain ...)? _____

Describe an ideal day in terms of weather and temperature: _____

What are your fears? _____

Do you have any hobbies? _____

(This question women only) What symptoms do you experience premenstrually? _____

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: _____

How is your energy? Is there any particular time of day when it is lower or higher? _____

How is your sexual interest/drive? _____

What do you most like to eat or crave? _____

What foods do you most dislike? _____

How is your thirst? _____

What temperature do you like fluids? _____

Are there any foods that you are sensitive to or allergic to? _____

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Registration Form. Continued...

Please place a check mark " ✓ " for any of these that apply to you

<table border="0" style="width: 100%;"> <tr><td style="text-align: center;"><input checked="" type="checkbox"/></td><td style="text-align: center;">Problem</td></tr> <tr><td><input type="checkbox"/></td><td>Frequent/severe headaches</td></tr> <tr><td><input type="checkbox"/></td><td>Back pains</td></tr> <tr><td><input type="checkbox"/></td><td>Neck lumps or swelling</td></tr> <tr><td><input type="checkbox"/></td><td>Loss of balance</td></tr> <tr><td><input type="checkbox"/></td><td>Dizzy spells</td></tr> <tr><td><input type="checkbox"/></td><td>Blackouts/fainting</td></tr> <tr><td><input type="checkbox"/></td><td>Wear glasses/contacts</td></tr> <tr><td><input type="checkbox"/></td><td>Blurry vision</td></tr> <tr><td><input type="checkbox"/></td><td>Eyesight worsening</td></tr> <tr><td><input type="checkbox"/></td><td>See double</td></tr> <tr><td><input type="checkbox"/></td><td>See halos or lights</td></tr> <tr><td><input type="checkbox"/></td><td>Watering eyes</td></tr> <tr><td><input type="checkbox"/></td><td>Earaches</td></tr> <tr><td><input type="checkbox"/></td><td>Hearing Difficulties</td></tr> <tr><td><input type="checkbox"/></td><td>Runny ears</td></tr> <tr><td><input type="checkbox"/></td><td>Noises in ears</td></tr> <tr><td><input type="checkbox"/></td><td>Dental problems</td></tr> <tr><td><input type="checkbox"/></td><td>Sore or bleeding gums</td></tr> <tr><td><input type="checkbox"/></td><td>Sore tongue</td></tr> <tr><td><input type="checkbox"/></td><td>Congested nose</td></tr> <tr><td><input type="checkbox"/></td><td>Running nose</td></tr> <tr><td><input type="checkbox"/></td><td>Sneezing spells</td></tr> <tr><td><input type="checkbox"/></td><td>Head colds</td></tr> <tr><td><input type="checkbox"/></td><td>Nosebleeds</td></tr> <tr><td><input type="checkbox"/></td><td>Sore throat</td></tr> <tr><td><input type="checkbox"/></td><td>Difficulty swallowing</td></tr> <tr><td><input type="checkbox"/></td><td>Hoarse voice</td></tr> <tr><td><input 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<input type="checkbox"/>	Numbness																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Leg cramps																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Skin problems																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Scalp problems																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Itching or burning skin																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Bruise easily																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Nervousness or anxiety																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Nervous with strangers																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Nail biting																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Difficulty making decisions																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Lack of concentration																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Loss of memory																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Lonely or depressed																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Frequent crying																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Hopeless outlook																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Difficulty relaxing																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Worry a lot																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Scary dreams or thoughts																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Feeling of desperation																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Shy or sensitive																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Dislike criticism																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Angered easily																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Annoyed by little things																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Family problems																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Problems at work																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Sexual difficulties																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Change of sexual energy																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Considered suicide																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Loss or gain in weight																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Loss of appetite																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Always hungry																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Fatigue or weariness																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Fever or chills																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Motion sickness																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Night sweats																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Hot flashes																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Warm/colder than others																																																																																																																																																																																																																																																																			
<input checked="" type="checkbox"/>	Problem																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Frequent belching																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Nausea																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Vomiting																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Pain in abdomen																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Bloated abdomen																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Constipation																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Loose bowels																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Black stools																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Grey or whitish stools																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Pain in rectum																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Itching rectum																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Blood with stools																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Frequent urination																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Involuntary urination																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Burning on urination																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Black or bloody urine																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Weak urine stream																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Difficulty starting urine																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Constant urge to urinate																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	<u>Women Only</u>																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Missed period																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Menstrual problems																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Bleeding between periods																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Heavy bleeding																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Bearing down feeling																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Vaginal discharge																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Genital irritation																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Pain on intercourse																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Swelling of breasts																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Painful breasts																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of pregnancies																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of births																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of miscarriages																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of premature births																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of caesareans																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	# of abortions																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	<u>Men Only</u>																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Burning of discharge																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Swelling on testicles																																																																																																																																																																																																																																																																			
<input type="checkbox"/>	Painful testicles																																																																																																																																																																																																																																																																			

Comments or special problems:

Active Homeopathy, LLC

American Medical College of Homeopathy –1951 West Camelback Road, Suite 300; Phoenix, Arizona 85015
 Phone: 602-953-2469; email: myhomeopath@activehomeopathy.com; web: www.activehomeopathy.com

Registration Form - Family History

Please Place a " ✓ " in the appropriate column for any illness that you or your relatives have had

Illness	Self	Father	Mother	Brothers	Sisters	Child #1	Child #2	Child #3	Grandparents
Abnormal Periods									
Alcohol/Drugs									
Allergies									
Anemia									
Arthritis/Gout									
Asthma									
Bleeding problems									
Cancer									
Diabetes									
Eczema									
Empahsema									
Epilepsy									
Frequent Infections									
Heart Trouble									
Hepatitis									
High Blood pressure									
Kidney problems									
Mental Illness									
Migraines									
Polio									
Pneumonia									
Prostate problems									
Psoriasis									
Rheumatic Fever									
Stomach problems									
Stroke									
Thyroid problems									
Tuberculosis									
Ulcers									
Venereal Disease									
Weight problems									

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Please use this space for any additional information you would like to provide: