

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 (Child/Almost Adult) Please Print

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

Gender		Parent's Marital Status				# of Siblings
Male	Female	Single	Married	Divorced	Widowed	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Home Address: _____
 City, State, Zip: _____ Home Phone: () _____
 Mother's Name: _____ Work Phone: () _____
 Mother's Employer: _____
 Business/Work Address: _____
 Father's Name: _____ Work Phone: () _____
 Father's Employer: _____
 Business/Work Address: _____
 Person to be contacted in case of emergency: _____
 Address: _____ Phone #: () _____

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: _____
 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 teenage girls 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

✓	Problem	✓	Problem	✓	Problem
<input type="checkbox"/>	Frequent/severe headaches	<input type="checkbox"/>	Aching muscles or joints	<input type="checkbox"/>	Frequent belching
<input type="checkbox"/>	Back pains	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Neck lumps or swelling	<input type="checkbox"/>	Back or shoulder pains	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	Weakness in arms/legs	<input type="checkbox"/>	Pain in abdomen
<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	Painful feet	<input type="checkbox"/>	Bloated abdomen
<input type="checkbox"/>	Blackouts/fainting	<input type="checkbox"/>	Trembling	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Wear glasses/contacts	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Loose bowels
<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	Black stools
<input type="checkbox"/>	Eyesight worsening	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	Grey or whitish stools
<input type="checkbox"/>	See double	<input type="checkbox"/>	Scalp problems	<input type="checkbox"/>	Pain in rectum
<input type="checkbox"/>	See halos or lights	<input type="checkbox"/>	Itching or burning skin	<input type="checkbox"/>	Itching rectum
<input type="checkbox"/>	Watering eyes	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	Blood with stools
<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Nervousness or anxiety	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Hearing Difficulties	<input type="checkbox"/>	Nervous with strangers	<input type="checkbox"/>	Involuntary urination
<input type="checkbox"/>	Runny ears	<input type="checkbox"/>	Nail biting	<input type="checkbox"/>	Burning on urination
<input type="checkbox"/>	Noises in ears	<input type="checkbox"/>	Difficulty making decisions	<input type="checkbox"/>	Black or bloody urine
<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	Lack of concentration	<input type="checkbox"/>	Weak urine stream
<input type="checkbox"/>	Sore or bleeding gums	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	Difficulty starting urine
<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	Lonely or depressed	<input type="checkbox"/>	Constant urge to urinate
<input type="checkbox"/>	Congested nose	<input type="checkbox"/>	Frequent crying		
<input type="checkbox"/>	Running nose	<input type="checkbox"/>	Hopeless outlook		Girls Only
<input type="checkbox"/>	Sneezing spells	<input type="checkbox"/>	Difficulty relaxing	<input type="checkbox"/>	Missed period
<input type="checkbox"/>	Head colds	<input type="checkbox"/>	Worry a lot	<input type="checkbox"/>	Menstrual problems
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Scary dreams or thoughts	<input type="checkbox"/>	Bleeding between periods
<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Feeling of desperation	<input type="checkbox"/>	Heavy bleeding
<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Shy or sensitive	<input type="checkbox"/>	Bearing down feeling
<input type="checkbox"/>	Hoarse voice	<input type="checkbox"/>	Dislike criticism	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	Wheezing or gasping	<input type="checkbox"/>	Angered easily	<input type="checkbox"/>	Genital irritation
<input type="checkbox"/>	Frequent coughing	<input type="checkbox"/>	Annoyed by little things	<input type="checkbox"/>	Pain on intercourse
<input type="checkbox"/>	Cough up phlegm	<input type="checkbox"/>	Family problems	<input type="checkbox"/>	Swelling of breasts
<input type="checkbox"/>	Cough up blood	<input type="checkbox"/>	Problems at work	<input type="checkbox"/>	Painful breasts
<input type="checkbox"/>	Chest colds	<input type="checkbox"/>	Sexual difficulties		
<input type="checkbox"/>	Rapid or skipped heart beats	<input type="checkbox"/>	Change of sexual energy	<input type="checkbox"/>	# of pregnancies
<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	Considered suicide	<input type="checkbox"/>	# of births
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Loss or gain in weight	<input type="checkbox"/>	# of miscarriages
<input type="checkbox"/>	Swollen feet or ankles	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	# of premature births
<input type="checkbox"/>	Armpits or groin swelling	<input type="checkbox"/>	Always hungry	<input type="checkbox"/>	# of caesareans
<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	Fatigue or weariness	<input type="checkbox"/>	# of abortions
<input type="checkbox"/>	Motion Sickness	<input type="checkbox"/>	Fever or chills		
<input type="checkbox"/>	Excessive sweating	<input type="checkbox"/>	Motion sickness		Boys Only
<input type="checkbox"/>	Recurring indigestion	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Burning of discharge
<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	Swelling on testicles
<input type="checkbox"/>	Are you ticklish	<input type="checkbox"/>	Warm/colder than others	<input type="checkbox"/>	Painful testicles

Comments or special problems:

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Registration Form - Family History <<>> Please Place an X 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									
Emphysema									
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 the space below to add any additional information you feel is important to convey.