ERIN BELLIS
DMHS REGISTERED HOMEOPATH

RIGHT FIT
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Homeopathic Consultation Form

Name: _____ Date of Birth: D_____ M_____ Y_____

Address: _____
Street *City* *Postal Code*

Telephone # Home _____ Work _____ Other _____

E-mail Address: _____

Referred By: _____ Present Doctor and Phone #: _____

Major Complaint in Order of Importance For You:

Complaint	*Since*	*Causes*

Which Medications Are You Currently Taking?

Medications	*Since*	*Causes*

What Other Treatments or Regimes Are You Currently Following?

Treatment of Regime	*Since*	*Causes*

Please check which of the following substances you are currently using?

Alcohol	How much? _____	Pain Killers	How much? _____
Chewing Tobacco	How much? _____	Recreational Drugs	How much? _____
Cigarettes	How much? _____	Sleeping Pills	How much? _____
Coffee	How much? _____	Supplements/Herbs	How much? _____
Laxatives/Purgatives	How much? _____	Tea	How much? _____

Please circle which of the following you have experienced or suffering from now:

Abortion	Diabetes	Hepatitis	Mononucleosis	Strep Throat	Whooping Cough
Alcoholism	Eczema	Herpes	Mumps	Sinusitis	Worms
Allergies	Epilepsy	Influenza	Nosebleeds	Stroke	Yellow Fever
Anemia	Emphysema	Jaundice	Parasites	Sun Stroke	
Appendicitis	Gall Stones	Kidney Disease	PCOS	Syphilis	Other:
Arthritis	Goitre	Leukaemia	Pneumonia	Thyroid Issues	_____
Asthma	Gonorrhoea	Liver Disease	Prostatitis	Tonsillitis	_____
Cancer	Gout	Lyme Disease	Psoriasis	Tuberculosis	_____
Chicken Pox	Hay Fever	Malaria	Rheumatic Fever	Urticaria	_____
Cold Sores	Heart Trouble	Measles	Sexual Abuse	Venereal Warts	_____
Depression	Hypertension	Miscarriage	Skin Diseases	Warts	_____

Any other major conditions?

_____

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

_____

_____

Age of first Menses: _____ Number of Pregnancies: _____

What Major Surgeries Have You Had?

Surgeries	*When*	*Complications*

What Major Injuries Have You Had?

Injuries	*When*	*Complications*

Please indicate below, which of the following aliments, or any other major aliments, which may be present in your family history:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Diabetes
Epilepsy	Gonorrhoea	Gout	Heart Disease	Mental Health Problems	Paralysis
Pneumonia	Skin Disease	Syphilis	Tuberculosis	Other: _____	

Relationship	*Age*	*If deceased, age of death*	*Cause of Death*	*Aliments*

Is there any other information that I would need to know?

_____

_____

_____

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 Erin Bellis is a homeopathic practitioner 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 Erin Bellis, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential.

Patient Signature: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____