

## HOMEOPATHY INTAKE FORM

NAME:

BIRTH DATE:

SEX:

MARITAL STATUS:

ADDRESS:

TELEPHONE:

EMAIL:

MEDICAL PROVIDER:

TELEPHONE:

Please list all medications you are currently taking, including birth control, HRT and any dietary supplements or botanicals:

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Please list medications and dates you have taken in the past:

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Please list any present or prior illnesses, including skin conditions, asthma, neurological disorders and sexually transmitted diseases:

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Surgeries and hospitalizations, and dates:

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Your chief concern:

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Natasha Zarrin is certified with the Council for Homeopathic Certification (CCH). She has agreed to abide by the Code of Ethics of this organization. Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the whole person, the homeopath regards the mental and emotional, in addition to physical aspects, as important.

### CONFIDENTIALITY

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to him or herself or others.

### CONSULTATION

I authorize discussion of my case notes with other professional homeopaths, should assistance in remedy selection and/or symptom analysis be required or my best interest be served by such a consultation. In so doing, my right to privacy will be protected by withholding my name and all other identifying information.

### CONSENT

I, \_\_\_\_\_, (client) am over 18 years old and have voluntarily chosen homeopathic care for myself/my child \_\_\_\_\_. I understand that Natasha Zarrin is a homeopath and not a medical provider, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and checkups for myself/my child. I further understand that Natasha Zarrin does not diagnose, treat or prescribe for any particular symptom, disease or condition. I understand that she will work on increasing my general vitality and constitutional strength and that any information presented is for educational purposes. Any decisions to reduce or change my allopathic medications will be made between my/my child's primary care physician and myself.

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SIGNATURE

\_\_\_\_\_

DATE

\_\_\_\_\_

NAME