

## ADULT MEDICAL HISTORY FORM

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Please complete this form and return to us before your first appointment along with a current photo of yourself that we can keep. Your doctor will review this information during your first appointment. Bring with you any nutritional supplements and medications that you may be taking.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip, Country \_\_\_\_\_ E-mail (optional) \_\_\_\_\_

\_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Referred By \_\_\_\_\_

Phone: home \_\_\_\_\_ cell \_\_\_\_\_ other \_\_\_\_\_

Fax: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse/Significant Other \_\_\_\_\_

In case of emergency, call \_\_\_\_\_ Phone \_\_\_\_\_

Insurance information (only if it covers our care) \_\_\_\_\_

\_\_\_\_\_

What brings you to consult us? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Significant health concerns and when they began (if not mentioned above)

1.

2.

3.

4.

Why did you choose homeopathic care? \_\_\_\_\_

\_\_\_\_\_

Is there anything about your life that you are unhappy about or would like to change?

\_\_\_\_\_

\_\_\_\_\_

On a scale of 1 to 10, how would you rate your current level of:

1. physical energy and vitality

2. mental and emotional well-being

Have you experienced any significant traumas in your life? If so, what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What have been the most difficult experiences or challenges? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Significant past health problems, accidents, hospitalizations or surgeries? (include dates)

1.

2.

3.

4.

Family history of serious illnesses? (who and what) \_\_\_\_\_

\_\_\_\_\_

Please include the following information on a separate sheet:

1. List of current medications and nutritional supplements (include dosages).
2. If you are seeing other physicians, please include their names and addresses.
3. Any upcoming diagnostic testing or medical or dental treatment?
4. Anything else you would like us to know about you?