Gleeson Clinic *Homeopathy Case History Form*

1304 E. Victoria Ave., Thunder Bay, ON., P7C 1C2 ☐ Faisal M.H. MD (Hom, Med, BHMS, PGCHP, PGTM
Phone: (807) 623-5531 or (807) 622-2132 Fax: (807) 626-9511

Personal History

Last Name: ________________________ First Name: __________________ Initial: ____

Street Address: ____

City: __________________________ Province: ___________ Postal Code: ____________

Home Telephone: (____)_________Work/Cell/Other Telephone: (____)_____________

Sex: M ( ) F ( ) Age: _____ Birth Date: (D/M/Y) _______________ No. of Children:__

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

Family/Primary Care Practitioner:

____

Referring Practitioner: (if any)

____

Education:________________________ Occupation:______________________________

Employer & Address:____

City: _______________________ Province: ______________ Postal Code:____________

Name and number of emergency contact: ______________________________________

Do you have coverage for homeopathy treatment under an extended health plan (either your own/ spouse's/parent's?) Yes ( ) No ( )

Did you ever take homeopathic medicines/treatment? ?) Yes ( ) No ( )

If yes, when and with whom? (Be specific) ______________________________________

PLEASE READ BEFORE COMPLETING THIS FORM

You have come here to get well. We are here to select to best medicine for you. To do that, we depend on your co-operation. HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know all the details of your problems. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past, your family, and mental make-up. We may be required to ask you a lot of questions. Each one of these questions a definite meaning and significance for us. Even something that you think is not connected with your trouble, may be the most important factor in deciding the correct homeopathic medicine. That is why you must be free and frank and give us the fullest possible information on each point. All the details will be kept confidential.

Please complete this form to the best of your knowledge. You may submit a written history or type it at your convenience. You may add extra pages if required.

Main Issues and Symptoms
Areas Affected:
Describe Sensation/Pain/Symptoms:
What aggravates the situation? :
What provides the relief? :
Any other symptom/sensation/pain appearing at the same time as the main complaints? (ex. Nausea, gas, hot flash, perspiration):

Secondary Issues and Symptoms
Areas Affected:
Describe Sensation/Pain/Symptoms:
What aggravates the situation? :
What provides the relief? :
Any other symptom/sensation/pain appearing at the same time as the main complaints? (ex. Nausea, gas, hot flash, perspiration):

Additional Personal Data
Description of your physique/body:
Describe your emotional nature and intellectual attainments and aspirations. Indicate to what extent you have been able to realize them (add an additional page if you desire to write more):
Give a clear-cut picture of your relationships with family members, friends, and associations:
Give a full description of your life starting from childhood (if you remember any details), teenage days, school life, college/university life, work life, etc.:
Write about any stressors or problems in life and how you handle them:
Mention the food you desire and food you avoid, plus any allergies:
How do the weather, sun, and temperature affect you?
Sleep, insomnia, average hours of sleep, going to sleep, and awake schedule:
Dreams that you often have:
Sex Health:
For females, Menstrual and Obstetric history:

Other Illnesses:
Illnesses that you have suffered in the past:
Family history of any diseases:

Medical Tests & Reports (if available):