NEW CLIENT INFORMATION FORM

Today's Date: _____

Name:_____ Birth Date:_____ Age: _____

Mailing Address: _____

Email Address: _____

Contact Phone Numbers: _____

Name/phone of Primary Care Physician: _____

Would you like progress reports of your homeopathic consultations to be sent to your physician? Y N

Conditions for which you are seeking assistance (please be specific):

Medications you are currently taking?
Include prescription, over the counter, or recreational drugs, also herbs and supplements please.

Have you used homeopathy before? If so, who was your practitioner? Remedies taken? Results?

Karen Allen, CCH Integrative Healthcare for Wellness and Fertility

www.karenallenhomeopathy.com phone: 415-944-8896 fax: 415-354-4220

The Flood Building, 870 Market Street – Suite 756, San Francisco, CA 94102

Please provide a brief health history. Note all major illnesses, hospitalizations , surgeries, skin conditions, major life or health events which were turning points in your life and your age at the time these events occurred.

Family health history. Note illnesses or health problems in all blood-related family members, along with cause of death for those who have passed away. Include Grandparents, parents, siblings, and children.

Please note any questions or concerns you would like to discuss as we begin.

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