Sandra Chadsey
Gentle Wellness Homeopathy & BioEnergetics

ADULT New Patient Intake Form

Personal Information

First and Last Name

Street Address City

Province Postal Code

Home Phone Cell Phone

Email

Date of Birth Age Sex

Family Doctor

Address City

Province Postal Code

Phone

Referred by

Name:

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Major medical complaints (In order of importance)

1. _____
   Since Cause
2. _____
   Since Cause
3. _____
   Since Cause
4. _____
   Since Cause

What medications are you currently taking?

Medication	Since	Adverse effects/Drug allergies

What supplements are you currently taking?

Supplement	How much?	How often?

Are You Currently Under the Care of a Physician(s)?

Physician	Condition?	Treatment(s)?

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What major INJURIES or SURGERIES have you had, if any?

Type: Location: Age:

Female

What was the age of your first menses? _____

Method of Birth Control? _____ How long? _____

Previous pregnancies? _____ Any miscarriages /abortions? _____

Complications with any of the above? _____

Menopause? _____ Start Date? _____

Lingering Complaints _____

Male

Any history or impotence, erectile dysfunction, prostate or urination problems?

When and what treatment occurred?

Complications with any of the above? _____

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Check any symptoms that you have experienced:

(in past 6-12 months)

- ☐ Abdominal cramping
- ☐ Anaphylactic shock
- ☐ Arthritic type symptoms
- ☐ Canker sores
- ☐ Celiac' s disease
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea or loose stools
- ☐ Difficulty concentrating
- ☐ Emotional upset
- ☐ Eczema
- ☐ Fatigue or sudden drops of energy after meals
- ☐ Gas or bloating
- ☐ Heartburn or indigestion
- ☐ Hives (Uticaria)
- ☐ Irritable Bowel syndrome (IBS)
- ☐ Irritability
- ☐ Itching – skin or rectal
- ☐ Migraine headaches
- ☐ Nausea
- ☐ Nocturnal enuresis
- ☐ Red rash around mouth, reddening or swelling of skin
- ☐ Rhinitis
- ☐ Runny nose
- ☐ Stiffness of joints
- ☐ Stomach ache
- ☐ Swelling of lips and face
- ☐ Swelling of the joints
- ☐ Vomiting
- ☐ Wheezing

Check any conditions that you have had in your lifetime:

- ☐ Abscesses
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety /Mood disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Gall Stones
- ☐ Goitre
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ Infertility
- ☐ Loss of Hearing
- ☐ Genital herpes
- ☐ Kidney/Bladder Disease
- ☐ Leukemia
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Parasites
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Schizophrenia
- ☐ Sexual abuse
- ☐ Skin Disease
- ☐ Strep Throat
- ☐ Sinusitis
- ☐ Stroke
- ☐ Sun stroke
- ☐ Syphilis
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Warts
- ☐ Whooping cough
- ☐ Worms
- ☐ Yellow fever

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If yes to any of the previous, please explain: (we will go in depth in the appt)

_____

_____

_____

_____

If experiencing any known allergies or intolerances

Which of the following trigger (or cause) the symptoms? Please check all that apply.

☐ Grass	☐ Dogs	☐ Perfumes	☐ Pollution
☐ Hay	☐ Horses	☐ Insecticides	☐ Exercise
☐ Mold & Mildew	☐ Other animals	☐ Odors	☐ Nervousness
☐ Basements	☐ Alcoholic Beverages	☐ Drafts	☐ Cold Air
☐ Leaves	☐ Cosmetics	☐ House dust	☐ Humidity
☐ Cats	☐ Aerosol sprays	☐ Smoke	☐ Weather Changes
☐ Latex (rubber)	☐ Other: _____		

When are your symptoms worse?

☐ Year Round			
☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

Do you live in a: ☐ House ☐ Apt / Duplex ☐ Condo / Town House

Do you live ☐ In the city ☐ In the suburbs ☐ Rural areas

Of Pets? Indoor /Outdoor ☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Other

Are there any tobacco smokers in your house? ☐ Yes ☐ No

Is your bedroom in the basement? ☐ Yes ☐ No

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Consent

I, _____ the undersigned, understand that Sandra Chadsey HOM, R.BIE is a Registered Homeopath and Bioenergetic (BIE) practitioner and **not** a licensed medical doctor.

- As such, I acknowledge that I am here on my own behalf and it is my right and responsibility, at any time throughout my care with Sandra Chadsey, to seek medical counsel and diagnosis, if so desired from a licensed medical doctor, for any present and/or future condition(s).
- I acknowledge that Sandra Chadsey does not diagnose or give direction on any current medications or diagnosis treatment plan from my licensed medical doctor.
- I reserve the right to terminate homeopathic and BIE treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy or BIE, that addresses my health in its entirety.
- I consent that after assessment, answering of questions, and discussion of homeopathic treatment options, to my satisfaction, I will voluntarily follow recommended treatment advice. I understand I can withdraw my consent at any time.
- In regards to BIE solely, I acknowledge that the GSR-120 unit is not intended to be used to diagnose, cure, prognosticate, treatment or prescribing of remedies for the treatment of disease or any act which will constitute the practice of medicine in this country in which a medical license is required.
- The GSR-120 unit is used to direct energy directly onto various acupuncture points on the body to help create homeostasis.
- Homeopathy is not covered by existing government medical insurance plans; therefore I agree to pay all fees incurred as presented in the current rate schedule.

_____
Patient's Signature:

_____
Date:

If under 18 years of age, a parent or guardian must sign on your behalf.

Thank you for taking the time to complete this form. All information contained herein will remain strictly confidential.