Tina Spathis RN,DCH
604-786-6095

Name: _____

List current health concern(s):

Have you seen an MD for your current problem(s)?_____

Have you/do you see an other alternative practitioners for you current or past condition?_

Have you taken homeopathic remedies before?_____

Past major illnesses:

Past Hospitalizations:

Have you ever had any adverse reactions to medications, vaccinations, etc.? Y/N

Medications:
Current:_____
_____
Past: _____
Vitamins, natural therapies:_____
Do you smoke? Y N If yes, how much?

Family History
Please list age, state of health and past major illnesses of family member. If deceased, include cause of death.

Father:_____
Father's mother:_____
Father's father:_____
Mother:_____
Mother's mother:_____
Mother's father:_____
Brothers and Sisters:_____
Your children:_____
Other family information;_____

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