Marijke's Intuitive Healing Services

HOMEOPATHIC HEALTH CLINIC

Name: Date:

Address: City:

Province: Postal Code:

Phone:

Email:

Would you like to receive the Riva's Remedies and Marijke's newsletters for health information, tips and health news for horses, dogs-cats and people?
Please check which newsletters you would like to receive:

___Horses ___Dogs-Cats ___People

BILLING INFORMATION:

Credit Card #:

Expiry Date: 3 Digit Security #:

Signature:

Note: Signature permits Marijke's Intuitive Healing Services to charge the above credit card for the set consultation fee. Consultation fees are not processed until after the health report is completed and received by the client.

FAMILY HISTORY: (List any significant medical conditions within your family):

HEALTH HISTORY:

Birthdate:_____

Which of the following surgeries have you had and what year?

___ Appendectomy
___ Gallbladder
___ Heart
___ Hysterectomy
___ Tonsillectomy
___ Vasectomy

Other: _____

# of Pregnancies:_____

HEALTH INVENTORY

Please mark P for past problems, O for occasional problems and F for frequent problems.

Respiratory	Digestive	Circulatory
___ Asthma ___ Bronchitis ___ Congestion ___ Ear Infections ___ Emphysema ___ Frequent Colds & Flu ___ Hay fever ___ Inhalant Allergies ___ Pneumonia ___ Sinuses ___ Strep Throat	___ Bloating ___ Constipation ___ Crohn's ___ Diarrhea ___ Diverticulosis ___ Gas ___ Heartburn ___ Hemorrhoids ___ Irritable Bowel ___ Ulcers	___ Blood Pressure – H / L ___ Chest Pain ___ Dizziness ___ Heart Disease ___ Heart Palpitations ___ Numbness / Tingling ___ Shortness of Breath ___ Stroke ___ Varicose Veins

Skin	Urinary	Joints & Muscles
___ Acne Rashes ___ Allergies ___ Dandruff ___ Dermatitis ___ Eczema ___ Hives ___ Psoriasis ___ Sweating ___ Warts	___ Bedwetting ___ Bladder Infections ___ Difficulty with Urination ___ Frequency of Urination ___ Incontinence ___ Kidney Disease ___ Kidney Infections	___ Arthritis ___ Rheumatoid ___ Osteroarthritis ___ Back Pain ___ Fibromyalgia ___ Head Injury ___ Joint Pain ___ Muscle Pain ___ Neck Pain ___ Osteoporosis

Mental & Emotional		
___ Anger ___ Anxiety ___ Concussions ___ Confusion ___ Crying ___ Depression	___ Fatigue ___ Fear ___ Grief ___ Hyperactivity ___ Indifferent ___ Insomnia	___ Irritability ___ Poor concentration ___ Poor memory ___ Sadness ___ Suspicious ___ Worry
General		
___ Cancer ___ Diabetes ___ Eating disorders ___ Epilepsy ___ Fatigue	___ Fluid retention ___ Headaches ___ Hepatitis ___ Thyroid ___ Vaccine reactions	
Hormonal		
___ Age of 1st Menses ___ Breast soreness ___ Fluid retention ___ Hair loss	___ Impotence ___ Irregular periods ___ Low libido ___ Menstrual cramps	___ Mood swings ___ Ovarian cysts ___ Uterine fibroids ___ Vaginal yeasts

Please list food allergies and intolerances:

Please list food cravings and favourite foods:

How much coffee do you drink per day?_____

Do you smoke? ☐ YES ☐ NO If so, how much?_____

Which medications are you currently taking?

Which vitamins/supplements are you taking?

What are your major health concerns?

Please send 2 pictures of yourself with this completed form:

1 portrait picture

1 full body shot

Marijke's Intuitive Healing Services
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