Jack Gagliardi, Homeopath
Homeopathic Medicine

Jack Gagliardi, Homeopath
18 Filmic Lane, Toronto, ON, M4M 3R1
416-832-3448 | www.homeopathyheals.com

Pre-consultation Questionnaire

Homeopathic Client Information

*Please note that all information provided is kept in the strictest confidence according to the regulations of Homeopath – patient confidentiality

LAST NAME:_____

FIRST NAME:_____

ADDRESS:_____

CITY:_____ **PROV**: _____ **POSTAL CODE**:_____

CONTACT NUMBERS

HOME: _____ **CELL:** _____ **WORK:** _____

EMAIL: _____

Date of Birth (MM/DD/YYYY):_____ **Marital Status**: _____

Number of Children: _____

Family Doctor: _____

Address: _____

City: _____ **Prov**: _____ **Postal Code**: _____

Phone: _____ **Fax**: _____

Emergency Contact Name: _____ **Relation**: _____

Emergency Contact Phone Number: _____

Occupation: _____ **Employer**: _____

Referred By: _____

Health Insurance Provider: _____

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

Complaint	Since	Causes

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

Medication	For What Condition?	Since	Any Adverse Effects?

WHAT NUTRITIONAL SUPPLEMENTS ARE YOU CURRENTLY TAKING?

Supplements	For What Condition?	Since	Any Adverse Effects?

WHAT OTHER TREATMENTS OR THERAPIES ARE YOU CURRENTLY FOLLOWING?

Therapy	Since	Results

HAVE YOU HAD ANY HEALTH PROBLEMS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL SINCE? WHICH ONES?

_____

WHAT OPERATIONS HAVE YOU HAD?

Operation	Date	Complications

HAVE YOU LOST ANY WEIGHT LATELY? _____ HOW MANY POUNDS? _____

MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES? IF SO, PLEASE LIST THEM:

_____

_____

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

Please circle any that apply:

Abscesses, Anemia, Arthritis, Asthma, Cancer, Chicken Pox, Cold Sores, Diabetes, Eczema, Emphysema, Epilepsy, Frequent Colds, Gallstones, Genital Herpes, Gonorrhea, Gout, Heart Disease, Hepatitis, HIV, Influenza, Kidney Disease, Leukemia, Lyme Disease, Malaria, Measles, Mononucleosis, Mumps, Parasites, Pelvic Inflammatory Disease, Peritonitis, Pleurisy, Pneumonia, Prostatitis, Psoriasis, Rheumatic Fever, Rubella, Scarlet Fever, Sexual Abuse, Skin Diseases, Sinusitis, Strep Throat, Stroke, Sunstroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid Fever, Venereal Warts, Warts, Whooping Cough, Worms, Yellow Fever
Other: _____

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE? (e.g. accident, illness, grief, mental upset etc.)

_____

ANY SERIOUS SHOCK, GRIEF, DISAPPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

_____

FAMILY HEALTH HISTORY (Please list age if alive, age at death, ailments, cause of death)

MOTHER: _____

FATHER: _____

BROTHERS: _____

SISTERS: _____

CHILDREN: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

MATERNAL AUNTS/UNCLES: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

PATERNAL AUNTS/UNCLES: _____

HAVE YOU HAD ANY OF THE FOLLOWING VACCINATIONS?

MEASLES □ MUMPS □ RUBELLA □ PERTUSSIS □ CHICKEN POX □ FLU □
OTHER: _____

ANY ADVERSE REACTIONS? _____

PERSONALITY PROFILE

Many times your health can be influenced by your mental/emotional state. As an aid to help determine the best homeopathic remedy for you, please circle any of the following characteristics that describe you best. Please bring the profile with you to your first appointment along with your pre-consultation intake form

Animated
Playful
Sociable
Convincing
Refreshing
Spirited
Promoter
Spontaneous
Optimistic
Funny
Delightful
Cheerful
Inspiring
Demonstrative
Mixes easily
Talker
Lively
Cute
Popular
Bouncy

Self-reliant
Positive
Sure
Outspoken
Forceful
Daring
Confident
Independent
Decisive
Mover
Tenacious
Leader
Chief
Productive
Bold

Sensitive
Planner
Scheduled
Orderly
Faithful
Detailed
Cultured
Idealistic
Deep
Musical
Thoughtful
Loyal
Caretaker
Perfectionist
Behaved

Controlled
Reserved
Satisfied
Patient
Obliging
Friendly
Diplomatic
Consistent
Inoffensive
Dry humour
Mediator
Tolerant
Listener
Contented
Permissive
Balanced

Brassy
Undisciplined
Repetitious
Forgetful
Interrupts
Unpredictable
Haphazard
Permissive
Angered easily
Naive
Wants credit
Talkative
Disorganized
Inconsistent
Show-off
Loud
Scatterbrained
Restless
Changeable
Adventurous
Persuasive
Strong-willed
Competitive
Resourceful

Bossy
Unsympathetic
Resistant
Frank
Impatient
Unaffectionate
Headstrong
Proud
Argumentative
Nervy
Workaholic
Tactless
Domineering
Intolerant
Manipulative
Stubborn
Short-tempered
Rash
Crafty
Analytical
Persistent
Self-sacrificing
Considerate
Respectful

Bashful
Unforgiving
Resentful
Fussy
Insecure
Unpopular
Hard to please
Pessimistic
Alienated
Negative attitude
Withdrawn
Too sensitive
Depressed
Introvert
Moody
Skeptical
Loner
Suspicious
Revengeful
Critical
Adaptable
Peaceful
Submissive

Blank
Unenthusiastic
Reluctant
Fearful
Indecisive
Uninvolved
Hesitant
Plain
Aimless
Nonchalant
Worrier
Timid
Doubtful
Indifferent
Mumbles
Slow
Lazy
Sluggish
Reluctant
Compromising

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PLEASE READ THE FOLLOWING CAREFULLY

*If under 18 years old, a parent or guardian must sign.

I,_____ the undersigned, understand that Jack Gagliardi is not a *medical doctor*, but instead a Homeopath. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Jack Gagliardi, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate homeopathic 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, that addresses my health in its entirety.

FEE SCHEDULE: (Payment Options: INTERAC, VISA, MasterCard, Cheque, Cash)

As homeopathy is not covered by existing government medical insurance plans, I agree to pay all fees incurred as presented in the current rate schedule below. (Rates are subject to change)

CHRONIC CASES:

INITIAL VISIT: $210 **INITIAL VISIT: CHILDREN UNDER 12 YEARS - $160**

OPTIONAL: Additional $50 for Live Blood Analysis (A Live Blood Analysis may be performed with your Initial Visit based on a recommendation by your Homeopath if he believes your case – depending on your medical condition - will benefit from the test **OR** at the request of the patient curious to see the state of their blood for informational purposes).

FOLLOW-UP VISITS: $60

ACUTE CASES: $25-$60 DEPENDING ON THE CASE

* Colds, flus, minor coughs, sore throats, healing after injuries (broken bones, bruising, pre and post-surgical treatment)

Remedy Refills without visit: (If applicable):** $14.61/ bottle

OTHER SERVICES:

• LIVE BLOOD CELL/NUTRITIONAL ANALYSIS/COUNSELLING $70

***Fees do not include HST ** Some remedy prices may vary**

***Some extended health care plans cover homeopathy**

Patient Name (Please Print): _____

Patient Signature: _____**Date:** _____

Preparing for Your Homeopathic Appointment which includes Live Blood Cell Analysis

Please remember to fast (no food) for at least 4 hours before every appointment (unless directed otherwise by your Homeopath). You may drink water.

Fasting will ensure an accurate Live Blood Cell Analysis.

Remember to bring a snack to eat after your blood is taken, as you may be hungry during the appointment.

If you have any questions, please do not hesitate to call (416-832-3448) or email me (jack@homeopathyheals.com).

YOUR FIRST HOMEOPATHIC APPOINTMENT
- REPORTING SYMPTOMS -

Determining the proper homeopathic remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your physical symptoms, individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation most effective, I request that you think about and keep in mind the following requests for information, as in-depth and accurately as possible. If you have any questions, feel free to contact me.

1. Think about, in detail, the onset of your symptoms. Any related mental, emotional or physical symptoms and/or any external condition(s) that may have contributed to your state of being at that time?

2. Think about all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these aliments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?

3. Think about the symptom you are experiencing in terms of location in the body. Does this symptom shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptom? How it feels/looks/smells/tastes? Anything that makes the symptom unique, striking or unusual? If pain is involved, think about the pain you endure ex. a dull ache vs. a sharp stabbing pain, a constant or periodic pain etc. Think about the onset of your pain; slow vs. sudden? How intense is the pain?

4. Make note of when your symptoms feel better or worse: time of day/ when you are hot or cold/hot or cold compresses/months/seasons/before or after eating/ sleep/moving resting certain positions/when occupied/ specific mental/emotional states. Experiment with heat or cold, warm rooms or fresh cool air, warm or cool bathing. Do you notice any difference in the symptom?

5. Are you affected in any way by different kinds of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by the seashore.

6. Urination (if of concern): Colour/ odour/ sediment/ quantity/ frequency/ urgency.

7. Stool (if of concern): Number of stools per day/ colour/ odour/ hard/ dry/ large/

pasty/ bloody/ frothy/ slimy/ thin/ watery/ slender/ flat/ difficult or incomplete/ urging without stool.

8. Menses: Length of cycle/ length of period/ significant pain associated with menses/ length of period/ nature of the flow/ clotting cramping PMS/ mood swings/ bloating swollen tender breasts/ Cravings/ vaginal discharge with or without menses.

9. Sex: Desires/aversion/ painful intercourse/ vaginal dryness/ impotency.

10. Perspiration: Profuse/ scanty/ odour.

11. Body Temperature: Hot vs. cold body type/ hot or cold hands or feet/ hot flashes.

12. Sleep: Do you wake up at night? When? Why? How do you feel in the morning on rising? What position do you sleep-side/back/front? Are parts of the body covered or exposed with sleep? Do you have recurring dreams in your sleep? Are there any prominent themes to your dreams? Night terrors?

13. What motivates you in life? Are there lasting traits from childhood that are still an issue today? Are there running themes in your life? eg. “All my life I’ve been...”. How would others describe you? How do you deal with change in your life? Do you need structure in your life?

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