**Anke Zimmermann, BSc, FCAH**
**Classical and Modern Homeopathy**
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# ADULT FORM

**This is a word document. Please type in the information. I will not accept hand-written and/or photographed intake forms, sorry. The form is also available in pdf form if that is easier. You can download it from my website at www.ankezimmermann.net under forms.**

Name _____

Street Address _____

City _____ Province: _____ Postal Code: _____

Country _____

Tel. Home: _____ Tel. Office: _____

Date of Birth _____ Present Age: _____ Blood Group if known: _____

Occupation _____

Marital Status _____ Name of Spouse: _____

Number of children and details (ages, sex) _____

_____

Medical Doctor and phone number _____

Emergency contact and phone number _____

Email: _____

Would you like to receive my newsletter – sent about 4 times a year? _____

Who referred you to this office? _____

## *Anke Zimmermann, B.Sc., F.C.A.H*

*Dear Client,*

*Welcome to my office. This questionnaire will help you to organize your thoughts for our initial meeting. You only need to fill out what you feel comfortable with. Please attach additional pages if needed.*

*I am the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please contact me and I will help you to decide how best to solve the issue.*

***Most of my work is online these days, but if you attend my office in person please be sensitive to the fact that some people are not able to tolerate the odour of cigarettes, perfume, cologne or after-shave lotions. Please come to the office smoke and fragrance free. Please note that I have a dog in case you are allergic to or afraid of dogs. He is normally crated when I see clients. Thank you.***

**FEE SCHEDULE (In Canadian Dollars)**

| | |
|---|---|
| Adult Initial Consult, 1.5 hours | $450.00 |
| First Follow-Up, 45 minutes | $180.00 |
| Follow-Up, 30minutes | $120.00 |
| Quick check-in, 15 minutes | $ 65.00 |

Telephone consultation.....varies with amount of time spent
Email consults…….....minimum 15min charge $50.00
NSF cheques.....$30.00
Medical - Legal reports.....varies with amount of time spent
Failure to keep a scheduled appointment.....cost of scheduled visit

All fees must be paid at the time of the visit including services, remedies and supplements and costs of laboratory tests.

**Please note: Forms of payment accepted are debit, credit, cash, cheque, email transfer or paypal.**

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## ACKNOWLEDGMENT

Anke Zimmermann uses non-invasive methods for the assessment of bodily dysfunction, and natural therapeutics for their correction, mostly homeopathy.

In order to avoid any confusion or misunderstanding, I request that all clients read and acknowledge the following:

_____ initial

•That you understand that Anke Zimmermann works within the homeopathic scope of practice, is not a medical doctor, and employs some methods which are not orthodox medical practice at this time, i. e. applied kinesiology.

_____ initial

•That you understand that care here and/or referral to other health professionals is based upon the assessment revealed through personal history and interview, physical assessment, laboratory testing, and sometimes methods that evaluate the electro-magnetic field of the body including applied kinesiology.

_____ initial

•That you understand homeopathic care is not generally covered under MSP at the present time and, therefore, you are responsible for any fees incurred while under treatment. Homeopathic care is covered under many private insurance plans and I will do my best to provide the appropriate documentation to your insurer upon request.

_____ initial

•That you are here as a client and are not attending my office for any other reason without making your intention known to myself or to the staff.

**Please be informed that you are required to give at least 1 business day notice in case you need to cancel or reschedule any appointment, including the initial one. I regret that otherwise you will be charged for the missed appointment**.

I greatly appreciate your consideration in this matter.

_____ Date

_____ Signature

# Consent for Care

Anke Zimmermann will take a thorough case history and may perform a physical examination if indicated and requested.

It is very important that you inform Anke of any disease process that you are suffering from and any supplements/medications/over the counter drugs that you are currently taking. Please advise immediately if you suspect you are pregnant, or if breast-feeding.

There are some health risks associated with the use of homeopathic remedies, herbs and supplements. These include but are not limited to the following:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Homeopathic remedies may stimulate healing or detoxification reactions, which may include loose stools, increased perspiration, skin eruptions and nasal discharges, among others. These reactions are relatively uncommon and normally pass within a few hours to days.
- Herbal tinctures can taste bad and may occasionally cause headaches or stomach discomfort.
- Nutritional supplements sometimes cause stomach discomfort. Niacin-containing supplements may cause skin flushing and itching.
- Rarely, individuals may experience allergic reactions to certain supplements and herbs. Please advise Anke immediately if you think that you have experienced an allergic reaction.
- Please let Anke know immediately should you experience any negative side-effects from any of your homeopathic and wellness care.

Important points to note:

- **Anke Zimmermann does not guarantee treatment results.**
- A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law. You are entitled to a copy of your records at any time and to transfer of your records to another practitioner if desired.
- Anke will explain to you the exact nature of any treatment provided and will answer any questions you may have to the best of her ability.
- You are free to withdraw your consent and to discontinue care at any time.

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I certify that I have read and understood the above **Consent for Care.**

Patient Name: (Please print name): _____

Signature of patient or guardian: _____

Date: _____

## Confidential Client Information

1. What is your main reason for attending this office? If this involves a specific health condition, please describe it in detail. In your own words, list the very first time that you noticed this condition and describe carefully any factors that you suspect may have played a role on its onset and development. Please list every detail and give me the opportunity to distinguish what may not be relevant to your case. Please attach a sheet if more space is required.

_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____

If this is a chronic complaint how long have you had it? _____

Who diagnosed your condition? _____

When was this diagnosis made? _____

What specialists have you seen and when?_____
_____

_____

_____

_____

_____

3. How has this complaint been treated until now, and what results have been obtained to date? _____
_____

_____

_____

_____

4. What other objectives do you have as far as your health is concerned?
_____

_____

_____

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_____

_____

_____

5. When were you last weighed? Date:_____
What is your present weight? Weight:_____
Has your weight changed over the past year?Yes:_____ No:_____

If yes, can you offer an explanation?

_____

_____

_____

6. What is your height?_____

7. How long has it been since you were totally well?_____

8. Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a. _____

_____

b. _____

_____

c. _____

_____

d. _____

_____

e. _____

_____

9. Are you currently working with a professional counselor, psychologist, social worker, or other therapist? Please provide details: _____

_____

10. Have you had homeopathic care before? Please provide details:

_____

_____

_____

Each line below represents a year in your life. I am asking you to draw a timeline of all major events in your life. This will assist me to assess your present health problems. Please indicate in chronological order all accidents, illnesses, hospitalizations, surgery, broken bones, sprains, falls, traumatic and emotional events, major changes in your life up to this point in time. I would also like to know when you had vaccinations, when you started school, changed schools, graduated, failed, got married, had children, separated, divorced, etc. Major life events and traumas can have long-lasting effects on health.

You can start with when you were born, or some people find it easier to begin at their present age and work backwards, it is your choice. You only need to include what you feel comfortable sharing of course.

Age 1_____
Age 2_____
Age 3_____
Age 4_____
Age 5_____
Age 6_____
Age 7_____
Age 8_____
Age 9_____
Age 10_____
Age 11_____
Age 12_____
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Age 86_____
Age 87_____
Age 88_____
Age 89_____
Age 90_____

Special Notes:

# FAMILY HEALTH HISTORY

Please indicate below which of the following ailments, or any other ailments, have affected your relatives. Please attach additional pages if needed. Include any peculiar characteristic of relatives who are similar to you in any way.

| | | | | | |
|---|---|---|---|---|---|
| **Alcoholism**<br>**Allergies**<br>**Alzheimer's**<br>**Arthritis** | **Asthma**<br>**Cancer**<br>**Depression**<br>**Diabetes** | **Epilepsy**<br>**Gonorrhoea**<br>**Gout**<br>**Hay Fever** | **Heart Dis.**<br>**Hypertensn.**<br>**Kidney Dis.**<br>**Mental Illness** | **Paralysis**<br>**Pneumonia**<br>**Skin Dis.**<br>**Digestive Disorders** | **Syphilis**<br>**Thyroid Disorder**<br>**Tuberculosis** |

| RELATIVE | AGE if alive | AGE if death | AILMENTS |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |
| **Brothers** | | | |
| **Sisters** | | | |
| **Maternal Grandmother** | | | |
| **Maternal Grandfather** | | | |
| **Maternal Aunts/Uncles** | | | |
| **Paternal Grandmother** | | | |
| **Paternal Grandfather** | | | |
| **Paternal Aunts/Uncles** | | | |

Thank you for completing this questionnaire. Please let me know if you would like a copy of your work, many people have found this very useful for further reference.

Anke Zimmermann, BSc, FCAH