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Basic Chronic Consultation Questionnaire (2 pages)

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of birth: _____ Age: _____ Male/Female: _____

Height: _____ Weight: _____

Relationship status: Single Married Divorced Widowed In a Relationship

Major Complaints in order of importance to you:

Complaint	How long ago	Describe related symptoms (How often do they occur? How long do they last?)	Rate (1-10)

I am 18 years of age or older and have voluntarily chosen homeopathy and/or natural wellness treatment for myself in order to increase my general vitality and constitutional strength. I understand that Angela Babb is not a medical doctor, and this is not medical advice. The information provided is for educational purposes and is intended solely as a sharing of knowledge and information. It is not intended to diagnose, treat, cure, mitigate, or prevent any symptom, disease, or condition nor replace a one-on-one relationship with a qualified health professional. I assume full responsibility for how I choose to use this information. I know that I am responsible for my own health and above all the lifestyle choices I make.

My signature below indicates that I have read and understood the Terms and Conditions (www.faithhomeopathy.com/terms-and-conditions), agree to abide by its terms, and hereby consent to homeopathic and natural wellness services.

_____

Print Client Name

_____

Client Signature (circle one) Self Parent Legal Guardian

_____

Date