

Intake Form

Please print this form and complete all of the following:

(if you don't have a printer you can fill out this form when you come for your appointment)

Name: _____ Age: _____

Birthdate: _____ Sex: Male Female

Address: _____

City: _____ Zip: _____

Phone: _____ e-mail: _____

Occupation: _____

Spouse Occupation: _____

How did you hear about us? _____

Are you familiar with ONDAMED Energy Medicine? Yes No

Are you familiar with Homeopathy? Yes No

What is the Level of your Health? Excellent ___ Good ___ Fair ___ Poor ___

Please List your most concerning health care problems at this time: _____

When did your chief problem or illness begin? _____

What do you think may have caused your chief complaint _____

We sometimes work with German Supplements and Creams called "Tissue Salts". These Salts are based on "Milksugar" (Lactose) Please answer the following questions so we know whether or not we can offer you this German resolution.

Do you suffer from Diabetes? Yes No Don't Know

Do you have Lactose (Milk) Intolerance: Yes No Don't Know

Did you ever had/have Tuberculous (TB)? Yes No

Do you suffer from Thyroid/Hormonal problems? Yes No Don't Know

Do you have a Pacemaker or any other Metals in your body? Yes No

Do you suffer from Dry Mouth? Yes No

Do you suffer from cancer? Yes No

How many Glasses of Water do you drink a day? _____

Are you Sweets addicted? Yes No

Do you suffer from Candida? Yes No Don't Know

Any recent Operations? Yes No

Do you suffer from HIV/Aids? Yes No

Please list your Medications: _____

Please tell us what kind of supplements or Vitamins you are taking: _____
