Stewart Homeopathy

Teresa Stewart CCH, C.HP

7101 York Ave, Suite 157, Edina, MN 55436

612-720-2332

**Client Registration**

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Birth Date:\_\_\_ \_\_\_\_\_\_\_\_\_\_

Relationship to Responsible Part : Self Spouse Son Daughter Other

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Name & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name, Address, & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I am the responsible party for (client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I

understand that payment of homeopathic services is due at time of service.

**Signature of Responsible Party:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Date: \_\_\_\_\_\_\_ \_\_ \_\_

**Homeopathic Services Notice**

The homeopathic services you have requested are directed at strengthening your constitution and vitality. They are not directed at identifying, treating or preventing specific diseases. Our practitioners are qualified homeopaths but are not licensed physicians. They are prohibited by law from diagnosing or treating disease.

If you have a medical complaint or question about your health it is important that you consult with a physician.

Many insurance companies do not pay for homeopathic services and our office will not be sending a claim to your insurance carrier.

**CLIENT ACKNOWLEDGEMENT:**

It is my personal preference to use the homeopathic services of the homeopaths at Minnesota Center for Homeopathy. I understand that the homeopathic services are NOT MEDICAL treatments and that these homeopaths are not licensed physicians.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­ \_\_\_\_ **Date:** \_\_\_ \_\_\_\_\_\_\_

**Parent Signature (if client is under age 18):**\_\_\_\_\_\_\_\_\_\_\_\_\_ ­ \_\_\_\_ **Date:** \_\_\_ \_\_\_\_\_\_\_

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**Client Bill of Rights**

We are pleased to provide you with this Client Bill of Rights, in accordance with Minnesota laws governing complementary and alternative health care practices.

1. **Degrees, training, and experience.**

Teresa Stewart is *a Council Certified Homeopath (CCH) and a* graduate of a 4 ½ year homeopathic training program with Northwestern Academy of Homeopathy (NAH), in the Twin Cities. She considers her education ongoing as she actively pursues continuing education. She is also enrolled in a Health couching program as a Functional Nutritionist. .

Teresa has a background in finance, working in corporate America from many years while pursuing her passion for health and healing. She fell in love with homeopathy in 1993, while raising her family in Australia. She works with families locally and remotely.

The current care you receive will be of a homeopathic nature and **not** allopathic (conventional medicine). Clients are advised to have and receive allopathic care from their primary care physician or provider. We will be pleased to coordinate your health care with your primary

physician according to your wishes.

In accordance with Minnesota law, I am providing you with the following notice:

**THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY**.

**Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time**.

1. **Right to file a complaint.** Our names and address are listed above. You have a right to file a complaint with us, by writing a letter with details of the nature of the complaint. Also, if you have any concerns, you may file a complaint with the following office:

Office of Unlicensed Complementary and Alternative Health Care Practice

Minnesota Department of Health Occupations Program

85 East 7th Place, Suite 300, PO Box 64882

St. Paul MN 55164-0882

651-282-3823, 1-800-657-3957, Fax 651-282-3839

1. **Fees for unit of service**. Fees are payable at the time of service by cash, check, or credit card. (See our Fee Schedule). We do not accept Medicare, Medical Assistance, or General Assistance Medical Care. We do not accept partial payment or waive payment. (See our Payment Policy).
2. **Change in services or charges.** You have a right to reasonable notice of changes in services or charges, and we will provide prior notice of any changes.
3. **Description of Services.**  Please see the article “What is Homeopathy,” provided to you in your clinic information packet, and available in our reception room.
4. **Information about assessment and recommended service.** You have a right to complete and current information concerning any assessment and recommended service, including the expected duration of the service to be provided. If you have any questions, please ask.
5. **Courteous treatment.** You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
6. **Confidentiality of client information.** Your records and other information about you are confidential. This information will not be released, unless you authorize release in writing, or unless release is required by law.
7. **Access to client records.** You are allowed access to records and other written information, in accordance with Minnesota Statutes, section 144.335.
8. **Other available services.** If you are interested in other available services in the community, you may wish to consult the Minnesota Homeopathic Association.
9. **Change practitioners.** You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
10. **Coordinated transfer.** If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.
11. **Refusing services.** You have the right to refuse services or treatment, unless otherwise provided by law.
12. **No retaliation.** You may assert your rights without retaliation.

***I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein and I have had a full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

Stewart Homeopathy

Health History Form

*This information is confidential and will only be released with your signed consent.*

Full Name: Today’s Date:

Address: **Birthdate:** Age:

Best way to contact you: Phone Voicemail E-mail

Phone: (C) (H) E-mail:

Sex: Gender Id/Pronoun(s): Height: Weight (optional.): Occupation:

Legal Status: Single Married Divorced Separated Widowed Living Situation:

Education (last completed):  Elementary  HS  College  Grad school  Vocational  Prof  Post-Grad

Emergency Contact: Relationship: Phone #:

If under 18, parents name(s)/address(es):

How did you hear of us / referred by?

Primary Physician: Other Physicians/Specialists:

Other Alternative Health Care Practitioners:

**The main reason(s) for my visit today are:**

**Family Health History**

*Check here if family history is unknown*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Age** | **If dead, cause of death** |  | **Children** | **Age** | **Problems** |
| **Father** |  |  |  |  |  |  |
| **Mother** |  |  |  |  |  |  |
| **Siblings** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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*Check the following items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Yes** |  | **Relationship** |  | **Yes** |  | **Relationship** |
|  | Alcohol/drug problem |  |  |  | High blood pressure |  |
|  | Allergy/asthma |  |  |  | High cholesterol/fat |  |
|  | Anemia |  |  |  | Kidney disease |  |
|  | Arteriosclerosis |  |  |  | Liver disease |  |
|  | Arthritis |  |  |  | Mental illness |  |
|  | Binge eating/bulimia |  |  |  | Obesity |  |
|  | Cancer |  |  |  | Skin disease |  |
|  | Diabetes |  |  |  | Suicide |  |
|  | Epilepsy/seizures |  |  |  | Syphilis |  |
|  | Gonorrhea |  |  |  | Thyroid disease |  |
|  | Heart disease |  |  |  | Tuberculosis |  |
|  | Other not mentioned |  |  |  | Ulcers |  |

**Past History of Illness and Medical Problems**

**Surgery: List all surgery When Other hospitalizations When**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
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**Broken bones and/or traumatic injuries  
include all car accidents or concussions Dates Major health complaints and duration Duration**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
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**Past History**

**Yes When Yes When**

|  |  |  |
| --- | --- | --- |
|  | Acne |  |
|  | AIDS/HIV |  |
|  | Alcohol/Drug problem |  |
|  | Allergies |  |
|  | Amalgams/silver fillings |  |
|  | Anemia |  |
|  | Antibiotics more than once a year |  |
|  | Anxiety |  |
|  | Arteriosclerosis |  |
|  | Arthritis |  |
|  | Asthma |  |
|  | Back pain/strain |  |
|  | Binge eating |  |
|  | Bladder infection |  |
|  | Blood clots |  |
|  | Breast fed |  |
|  | Breast lump |  |
|  | Bronchitis |  |
|  | Bulimia (self-induced vomiting) |  |
|  | Cancer |  |
|  | Cataract |  |
|  | Chemical sensitivity |  |
|  | Chicken Pox |  |
|  | Chronic fatigue |  |
|  | Coccidiomycosis |  |
|  | Colds, frequent |  |
|  | Colitis |  |
|  | Congenital defect |  |
|  | Counseling |  |
|  | Depression |  |
|  | Diabetes |  |
|  | Ear Infection |  |
|  | Eczema |  |
|  | Endometriosis |  |
|  | Epilepsy |  |
|  | Epstein Barr |  |
|  | Fibrocystic Breasts |  |
|  | Fibroids |  |
|  | Gallbladder problems |  |
|  | Glasses/contacts |  |
|  | Glaucoma |  |
|  | Gonorrhea |  |
|  | Gout |  |
|  | Hay Fever |  |
|  | Hearing Problem |  |
|  | Heart attack |  |
|  | Heart failure |  |
|  | Heart problem |  |
|  | Hemorrhoids |  |
|  | Hepatitis |  |
|  | Herpes |  |
|  | Hiatal Hernia |  |
|  | High blood pressure |  |
|  | High cholesterol/ triglycerides |  |
|  | Histoplasmosis |  |
|  | Hives |  |
|  | Hypoglycemia |  |
|  | Infectious Mononucleosis |  |
|  | Insomnia |  |
|  | Kidney infection |  |
|  | Kidney stones |  |
|  | Kidney problems |  |
|  | Liver disease |  |
|  | Measles |  |
|  | Menstrual problems |  |
|  | Mental Illness |  |
|  | Migraine |  |
|  | Mumps |  |
|  | Nervous condition |  |
|  | Neurological problems |  |
|  | Nightmares—frequent |  |
|  | Overweight >20lbs |  |
|  | Pelvic infection |  |
|  | Peptic ulcer |  |
|  | Periodontal disease |  |
|  | Phlebitis |  |
|  | Pneumonia |  |
|  | Premenstrual tension |  |
|  | Prostate problems |  |
|  | Psychotherapy |  |
|  | Reactions to vaccinations |  |
|  | Rheumatic fever |  |
|  | Root canals |  |
|  | Scarlet fever |  |
|  | Sexually transmitted disease |  |
|  | Sinusitis |  |
|  | Skin problem |  |
|  | Sleep disorder |  |
|  | Stroke |  |
|  | Suicide attempt |  |
|  | Syphilis |  |
|  | Taken steroid (cortisone/prednisone) |  |
|  | Thyroid problem |  |
|  | Tonsillitis |  |
|  | Tooth problems |  |
|  | Tuberculosis |  |
|  | Urine problems |  |
|  | Vaginitis |  |
|  | Vision problems |  |
|  | Warts |  |
|  | Other problems |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Personal History**

Current Medications (prescription and non prescription)

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Vitamin & Mineral supplements (type & Dosage)

|  |
| --- |
|  |
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|  |

**Allergies:**

I am allergic to the following medications, foods, chemicals or inhalants:

|  |
| --- |
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|  |
|  |
|  |
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|  |
|  |
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|  |
| --- |
| **Lifestyle:**  List your favorite foods or cravings: |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

I do the following for relaxation/recreation/fun/interest:

|  |  |  |
| --- | --- | --- |
| **Activity** |  | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

I am now or have been a smoker:  yes  no

How many years have you smoked?

When did you quit?

What do you smoke now?

How much?

I estimate my use of:

coffee:    cups/day decaf:    cups/day

tea:    cups/day soda:    cans/day

I use  beer  wine  “hard” liquor

I consider myself a:

non-drinker  social drinker  heavy drinker  alcoholic   
 recovering alcoholic

I use:  marijuana  other drugs:

I have participated in an exercise program:  yes  no

I exercise now on a regular basis:  yes  no

I find my work:

too demanding  boring  satisfactory  very satisfying

My sex life is satisfactory:  yes  no Libido: (scale 1-10)

|  |
| --- |
| I am sometimes fearful of: |
| being alone | darkness |
| robbers | sudden noises |
| high places | the unknown |
| animals/bugs (specify): | other (fire, accidents, etc): |
|  |  |
| I worry about: | job /work |
| money / security | family / family life |
| relationships | other: |

I sleep well:  yes  no Describe:

I currently see a psychotherapist or other mental health professional:

yes no

I currently see a chiropractor, osteopath, rolfer, massage therapist or other body work professional. yes no Note:

I have been arrested:  yes  no Note:

I have been in the military  yes  no

I have been a victim of abuse:  physical  emotional  sexual

Notes:

My spiritual life is satisfactory:  yes  no

I am currently involved in a regular spiritual program  yes  no

My last physical exam was

**Review of Systems** Answer “yes” if you have had these symptoms **in the** **past 12 months**

.

**Yes Yes Yes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Chronic fatigue | | | |
|  | Mood swings | | | |
|  | Chronic depression | | | |
|  | Trembling episodes | | | |
|  | Light-headedness | | | |
|  | Food cravings | | | |
|  | Frequent infections | | | |
|  | Night Sweats | | | |
|  | Swollen glands | | | |
|  | Skin rash | | | |
|  | Chills/fever | | | |
|  | Change in skin/nails | | | |
|  | Change in wart or mole | | | |
|  | Abnormal bleeding/bruising | | | |
|  | Unusual hair loss/growth | | | |
|  | Change in hair loss/growth | | | |
|  | Irritability | | | |
|  | Restlessness | | | |
|  | Headaches | | | |
|  | Dizziness | | | |
|  | Balance problems | | | |
|  | Head injury | | | |
|  | Seizure/convulsions | | | |
|  | Poor memory | | | |
|  | Difficulty concentrating | | | |
|  | Fainting | | | |
|  | Weakness | | | |
|  | Numbness/tingling | | | |
|  | Blurred vision | | | |
|  | Double vision | | | |
|  | Loss of any vision | | | |
|  | Halos around lights | | | |
|  | Excessive tearing/itching | | | |
|  | Eye pain | | | |
|  | Dark circles under the eyes | | | |
|  | Date last eye exam | | | |
|  | Loss of hearing | | | |
|  | Ringing/buzzing in ears | | | |
|  | Sinus trouble | | | |
|  | Nosebleed | | | |
|  | Sore throat | | | |
|  | Hoarseness | | | |
|  | Change in voice | | | |
|  | Dental problem | | | |
|  | Dry mouth | | | |
|  | Excessive salivation | | | |
|  | Bleeding gums | | | |
|  | Mouth breathing | | | |
|  | Chronic cough | | | |
|  | Bloody/yellow sputum | | | |
|  | Shortness of breath | | | |
|  | with exertion | | | |
|  | at night | | | |
|  | Bronchitis | | | |
|  | Chest pain with breathing | | | |
|  | High blood pressure | | | |
|  | Chest pain or pressure | | | |
|  | at rest | | | |
|  | with exertion | | | |
|  | with stress | | | |
|  | with eating | | | |
|  | down left arm, neck or back | | | |
|  | accompanied by nausea, sweating, anxiety | | | |
|  | Irregular heartbeat | | | |
|  | Skipped heartbeats | | | |
|  | Palpitations | | | |
|  | Fast heart beat | | | |
|  | Heart murmur | | | |
|  | Swelling feet/legs | | | |
|  | Cold hands/feet | | | |
|  | Leg cramps at night | | | |
|  | Pain or fatigue in legs with exercise | | | |
|  | Burning feet | | | |
|  | Sore legs/feet | | | |
|  | Color change legs/arms | | | |
|  | Difficulty swallowing | | | |
|  | Pain/discomfort when eating | | | |
|  | Bad teeth | | | |
|  | Belching | | | |
|  | Coating on tongue | | | |
|  | Pain relieved by eating | | | |
|  | Nausea/vomiting | | | |
|  | Trouble with fried foods | | | |
|  | Bloating of abdomen | | | |
|  | Bowel gas | | | |
|  | Diarrhea | | | |
|  | Constipation | | | |
|  | Black stool | | | |
|  | Clay-colored stool | | | |
|  | Mucus in stool | | | |
|  | Hemorrhoids | | | |
|  | Rectal bleeding | | | |
|  | Abdominal pain | | | |
|  | Change in diet | | | |
|  | Pain/burning during urination | | | |
|  | Frequent urination | | | |
|  | Urination at night | | | |
|  | Blood in urine | | | |
|  | Loss of control/urine | | | |
|  | Foul odor to urine | | | |
|  | Low back pain | | | |
|  | Muscle pain | | | |
|  | Where: | | | |
|  | Muscle weakness | | | |
|  | Where: | | | |
|  | Joint pain | | | |
|  | Where: | | | |
|  | Joint pain aggravated by motion | | | |
|  | Joint pain relieved by motion | | | |
|  | Swollen joints | | | |
|  | Stiff joints | | | |
| **MEN** | |  | | |
|  | Enlarged prostate | | | |
|  | Decreased urine stream | | | |
|  | Unable to interrupt urine stream | | | |
|  | Dribbling after urination | | | |
|  | Pus or drainage from penis | | | |
|  | Genital swelling/rash | | | |
|  | Problem with sexual function | | | |
| **WOMEN** | | |  | |
| Last menstrual period | | | |  |
| Age began menstruation | | | |  |
| Age at menopause | | | |  |
| # of pregnancies | | | |  |
| # of live births | | | |  |
| # of abortions/miscarriages | | | |  |
| Usual length of cycle | | | | days |
| Usual length of period | | | | days |
| Date of last Pap smear | | | |  |
|  | Complication of pregnancy | | | |
|  | Used birth control pills | | | |
|  | Used IUD | | | |
|  | Change in cycle | | | |
|  | Spotting between periods | | | |
|  | Discomfort with periods | | | |
|  | Premenstrual tension | | | |
|  | Vaginal discharge | | | |
|  | Painful intercourse | | | |
|  | Itching | | | |
|  | Self breast examination | | | |
|  | Problem with sexual function | | | |
|  | Lump in breast | | | |
|  | Abnormal pap smear | | | |
|  | Infertility | | | |
|  | Breast fed a baby | | | |
|  | Other: | | | |

**Life Changes**

In the last 12 months, what changes have occurred in your life

**Personal Life**

**Family Life**

**Social Life**

**Work Life**

**Sex Life**

**Any other significant changes**

**Lifestyle Comments**

**Please add anything that you would like to tell us that has not already been covered**