 Print and fill the forms: fax, email or mail to our office before you make an appointment.
Please bring this form on your appointment day

Ph: (760) 245-2890 Fax: (760) 994-1374

www.homeopathyphysician.com email homeopathicdrpal@yahoo.com

NEW PATIENT HISTORY FORM

To our new patients: To help us establish you with our Homeopathic practice, please provide us with your complete health history including all Physical and Mental symptoms.

Date -_____

Personal History

Name: _____ Date of Birth____/____/_____(mm/dd/yyyy) Age_____

Occupation _____ Birthplace_____(City & Country)

Height _____inches Weight_____(lbs or Kg)

Referred by:_____

Preferred Language for consultation –1st_____2nd_____ (English, Hindi, Urdu, Punjabi)

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc...

_____

MAIN PROBLEMS/ REASONS FOR THIS CONSULTATION: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like to be addressed:

_____

_____

_____

*Note: we may not be able to address every problem during the course of one treatment.

Current Medications	Dose	Times / Day
Current Herbs / Vitamins/ Homeopathy/ Supplements	**Dose**	**Times / Day**

PAST MEDICAL, SURGICAL & TRAUMA HISTORY **Patient Name:**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

_____

_____

_____

_____

_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							

SOCIAL HISTORY (check those that apply): **Patient Name:**

Marital status:
- ☐ single
- ☐ married
- ☐ divorced
- ☐ Widowed

Education level completed:
- ☐ high school
- ☐ college
- ☐ professional school
- ☐ other:

Memories of your childhood
- ☐ Mostly happy
- ☐ Mostly painful
- ☐ Normal
- ☐ don't recall

Do You Find Your Life
- ☐ Generally Unsatisfactory
- ☐ Too Demanding
- ☐ Boring
- ☐ Satisfactory

Living arrangement:

☐ alone ☐ family ☐ roommate ☐ significant other

☐ children (list sex/ages):_____

☐ Major stresses in last 2 years ☐ Money ☐ Job ☐ Marriage ☐ Home Life ☐ Children

☐ other stress_____

Pertinent travel history:(out of USA, epidemic areas)

_____

_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many? #_____yrs. _____ packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit? _____
Do you drink alcohol?	☐ YES ☐ NO	If yes, how much? Type_____ & _____ drinks per week
Do you drink caffeine beverages?	☐ YES ☐ NO	If yes, which? _____
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which? _____
Do you manage stress well?	☐ YES ☐ NO	☐ NOT SURE ☐ NEED HELP
Do you exercise regularly?	☐ YES ☐ NO	If no, why? _____
Do you enjoy your job?	☐ YES ☐ NO	If no, why? _____
Do you allow time to unwind and relax?	☐ YES ☐ NO	If no, why? _____
Do you sleep soundly?	☐ YES ☐ NO	If no, why? _____
Are you satisfied with your sex life?	☐ YES ☐ NO	If no, why? _____
Are you satisfied with your social life?	☐ YES ☐ NO	If no, why? _____
Are you satisfied with your spiritual life?	☐ YES ☐ NO	If no, why? _____
Is your diet healthy enough?	☐ YES ☐ NO	☐ NOT SURE ☐ NEED HELP

Typical breakfast_____

Typical lunch _____

Typical dinner_____

Typical snacks_____

Devices

Do You Use:

___Eyeglasses _____Contact Lens _____Hearing Aid _____Dentures

___Brace (Neck, Back) _____ Pacemaker _____ IUD, Diaphragm _____Artificial Limbs

REVIEW OF SYSTEMS **Patient Name:**

Check any symptoms that currently apply to you:

Constitutional
___ poor appetite
___ fevers
___ chills
___ food craving
___ weight loss
___ weight gain
___ fatigue

Eyes
___ eye pain
___ blurred vision
___ poor vision___day
___ poor vision___night
___ wear corrective lenses
___ near____far sighted
___ other

Ears, Nose
___ ringing ears
___ nosebleed/polyp
___postnasal drip
___sinus problems
___trouble with taste/smell
___poor hearing
___earaches/ infections
___sneezing/ discharges

Mouth, Throat
___ tongue discoloration
___ bad breath
___ teeth problems
___ grinding teeth
___ tonsillitis/ adenoids
___ facial pain
___ sore throat
___ ulceration tongue
___ gum bleeding

Heart & Circulation
____chest pain
_____ lightheadedness
___ palpitations
_____ cold hands/feet
_____ fainting
_____ swelling feet
_____ blood clots
_____ varicose veins

Breathing & Lungs
_____shortness of breath
_____wheezing or asthma
_____repeated colds/ flu
_____ cough dry/ irritating

Muscles, Bones & Joints
____neck pain
____back pain
____muscle pain
____ painful joints: R__L__
____shoulder ____elbow
____hip____ knee ___ankle
____wrist _____fingers
____joint swelling
____muscle weakness
____muscle cramps

Skin, Hair
_____ psoriasis
_____ warts
_____ freckles
_____ itching, hives
_____ hair loss
_____ dry skin, eczema

Nerves, Movement, Brain
_____ seizures
_____nerve pain
_____poor balance
_____poor coordination
_____tremors or shaking
_____headaches

Digestion & Intestines
____indigestion
____belching/ flatulence
____difficulty swallowing
____heartburn/ ulcer
____nausea
_____ liver trouble
_____ vomiting
_____ diarrhea
_____ cramping bowels
_____ food allergies
____constipation
_____ abdominal pain
____rectal pain/ itching
_____ hemorrhoids/ piles
_____ blood in stool

Urine, Kidney, Bladder
____painful urination
_____wake up to urinate
_____kidney stones
_____ loss of control
_____ frequent urination
_____ sudden urging
_____ blood/pus urine
____urine infection UTI

Immune System
_____too many infections
____allergies to food
____allergies to environment
___ other concerns

Blood System
____lymph gland swelling
____anemia
____easy bruising

Mind Symptoms
____memory
____temper/anger
____emotional
____sleep

Sexual Organs
_____ sores on genitals
_____ lumps or swelling
_____ erection problems
_____ premature ejaculation
_____pain with sex
____infertility
____repeated infections
____aversion to sex

Thermal State
___hot
___chilly

Women
_____ pelvic pain
_____ vaginal discharge
_____ painful periods
_____premenstrual syndrome
_____ hot flashes
_____ itching or soreness
_____irregular menses
_____leucorrhoea

Reproductive
____age period started
_____ # of pregnancies
____# abortions
____# miscarriages
____# live births
___children currently living
___age menopause ___
___past infertility

Additional Symptoms --

_____

_____

_____

IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/ OR NON-PERTINENT.

HEALTH SCREENING HISTORY **Patient Name:**

List the date of your most recent test or exam.

Mammogram _____ Pap Smear_____ Self Breast Exam _____Breast Exam by Doctor_____

Blood test for Cholesterol _____ Blood Sugar _____Other Blood tests_____

Immunizations: Tetanus_____Hepatitis_____MMR_____Flu Shot_____

Test for Blood in stool_____ Rectal Exam _____Feeling the Prostate_____ Scope Lower Bowel_____

Self Exam Testicle _____Testicle Exam by Professional_____

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	EKG	EEG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

Copies of lab reports should be sent with this form

Pictures should be sent with the patient form (Virtual Consultation only)

Mailing Address -- **PAL**
14534 GRAHAM AVE
VICTORVILLE, CA
USA 92394

This history record has been designed to facilitate our patients to assess their health issues in detail.

Once Homeopath Pal reviews this history record and reports he will be asking you specific questions pertaining to your symptoms to get a complete disease picture. *Each symptom will be completed regarding its location, extension, sensation, modalities and concomitants during the* virtual or in office consultation process.

A complete case record thus created will be analyzed for a Homeopathic prescription. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.

_____

Date Patient/ Guardian signature that filled out the history

Mailing Address

_____

_____

Phone – Home -- _____

Cell -- _____

Email -- _____

For more information visit www.homeopathyphysician.com see virtual consultation tutorial

Authorization for the release of Medical Records

Patient Name _____ Today's Date _____

Patient SSN _____ Date of Birth _____

Person(s), Class of Persons or Organization to Release Information to Singh S Pal.

Name _____ Mailing Address _____

City _____ State _____ Zip _____ Phone # _____ Fax# _____

Singh S Pal Office to receive information at: 14359 Amargosa Rd Ste T, Victorville CA 92392
Ph (760) 245-2890 Fax (760) 994-1374 email homeopathicdrpal@yahoo.com

Description and Purpose of the Information to be released:

_____

Expiration Date or Related event that will cause Authorization to expire:_____
(If no expiration date is specified, this authorization will expire one (1) year from the date it was signed).

By signing this form, I authorize the release of protected health information about me (or another person for whom I have authority to sign) to Singh S Pal for the time period, purpose, and extent described above. My signature indicates that I fully understand and acknowledge the following:

• My health record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, blood alcohol and drug testing, and treatment for alcohol and drug abuse.

• The protected health information to be used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal law.

• I have the right to refuse to sign this authorization. CPC will not condition treatment, payment, enrollment, or benefits eligibility on my signing this authorization.

• I have the right to revoke this authorization in writing at any time to the extent that the use or disclosure has not already been made. I may do so in person at the office where my records are maintained.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Name of Patient or Authorized Representative (please print) Relationship to Patient (please print)

Homeopathic Practitioner Singh S Pal, D.H.M.S. *(Diploma in Homeopathic Medicine Surgery & Midwifery)*

Practitioner Disclosure & Client Consent Form

Welcome to my Holistic Homeopathic practice. As per the requirements of the Senate Bill 577 it is informed that I am not a licensed physician nor the Homeopathic services licensed by the state. This mode of treatment is alternative or complimentary to the healing arts services licensed by the state.

Homeopathic system of treatment consider person as a whole entity with his mental, physical and emotional symptoms. It does not put a diagnosis label on the person. When Homeopathic case taking is done, it contains complete details of every symptom regarding its causation, location, duration, sensation, extension, modalities, concomitants including any peculiar or keynote symptoms. Past ailments and family history are also considered while prescribing. It is called as symptom totality.

The symptom totality is then matched with the drug picture. Closest/ perfect match – faster the recovery. Computerized system helps in matching the drug picture to the symptom totality, which is second important step after case taking. Last but not the least counts the professional capability and experience in Homeopathic system of medicine which helps the individual to recover and regain healthy state. Homeopathic treatment helps increase immunity of the body.

Education, Training and Experience – *I did my D.H.M.S (Diploma in Homeopathic Medicine Surgery & Midwifery) a 4 years full time course with 24 core/elective clinical rotations at General Hospital Chandigarh and 6 months clinical internship from Homeopathic Medical College Chandigarh, India. I was registered as a Homeopathic Doctor in states of Punjab, Haryana and Chandigarh INDIA. I am practicing Holistic Homeopathy for the last 25 years.*

In order to use my services, California State requires that you acknowledge receipt of the information provided in this form by signing it. You will receive a copy. I will keep the original in my record for three years. I will provide Homeopathic therapy, subject to requirements and restrictions of Senate bill 577. If you have any concerns about the nature of your treatment, please feel free to discuss with me. Please remember that doctors, nutritionists, herbalists, and other medical professionals and health practitioners hold widely varying views. I intend to offer health information to help you cooperate with a competent medical doctor (MD) in your mutual quest for health. I recommend that you inform your medical doctor that you are receiving Homeopathic treatment.

Acknowledgement and Consent to receive services

I have read and understood the above disclosure about the Homeopathic therapy offered by Singh S Pal and his training and education. I have discussed about the nature of treatment to be provided. I understand that he is not a licensed physician and that his services are not licensed by the state. I understand my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered and agree to be personally responsible for the fees in connection with the services he provide me.

Name:_____ (Minor)

Signed: _____ Date:_____

Self/ Parent/ Guardian: _____(Print name)

Appointment Cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

How to Cancel Your Appointment

In order to be respectful of the needs of all patients, if it is necessary to cancel your reserved appointment we require that you contact our office by 10:00am one (1) working day in advance. Appointments are in for convenience and availability and your early cancellation will give another person the possibility to access timely homeopathic consultation.

To cancel an appointment, please call (760) 245-2890 to speak with an office representative. If you do not reach an office representative, you may leave a detailed message on the office voicemail. You may not cancel a scheduled appointment via email.

No Show Policy

A 'no show' appointment occurs when a patient misses an appointment without canceling by 10:00 A.M. one (1) working day in advance. No show inconveniences patients who need access to homeopathic care in a timely manner. **Last minute/late cancellations are considered 'no show' appointments.**

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a 'no show'. The first 'no show' will result in a **$25** fee being applied to your account, as well as an email or a letter being sent to your home alerting you that an appointment was missed without canceling. If there is a second 'no show' a **$50** fee will be billed to your account and a second email/letter will be sent. A third 'no show' will result in suspension of services and dismissal from our homeopathic office.
Exceptions to this policy must be approved by the Office Manager.

By signing below I certify that I have read and understand the terms and conditions of Homeopathic Office appointment cancellation policy:

Authorization: I_____ authorize Pal Homeopathy to Charge my credit

card No._____ expires_____ CVV_____

for all applicable no show fee.

X_____
Patient/Parent/Guardian Signature Date