**Kristina Samoilova Lic.I.S.H. I.S.Hom**

**Registered Homeopath**

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**Consent form regarding your Data Protection**

**Privacy Statement**

***Please give me permission to use information you have supplied by deleting as appropriate the YES/NO at the end of this section:***

* To use personal information to analyse the conditions for which I have been consulted
* To hold personal data, health records, homeopathic prescriptions and related details which are legitimately important for homeopathic treatment.
* To communicate with you by phone, text or email – as appropriate.
* To recommend referrals to other colleague Homeopaths, GP or other relevant professional where necessary.
* I understand that Kristina Samoilova will never make changes to prescription medications prescribed by any other medical professional or therapist.
* I understand that at any time I can request that the personal information not be used for these purposes by contacting Kristina Samoilova.

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

**CLIENT’s DETAILS**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth: |  |
| Phone no: |  |
| Email: |  |
| Address: |  |
| Outline of presenting complaint and symptoms: |  |
| Current or recent medications and dosage (including food/vitamin supplements): |  |
| Medical history of illnesses, injuries, and operations/hospital interventions – as far back as you can remember - please include childhood events: |  |
| GP’s Name and Contact No: |  |
| Occupation: |  |
| Number of children, age, gender: |  |
| Marital Status: |  |
| HOMEOPATHIC TREATMENT:  (If you previously had homeopathic treatment, list the prescribed remedies if known) |  |

**FAMILY HISTORY**

If there is a family history of the following conditions, please tick the appropriate box. Please add any other conditions if not included on the list.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| M=Male F=Female | Grandparents | | Parents | | Siblings | | Children | |
| M | F | M | F | M | F | M | F |
| Heart Disease |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |
| Thyroid |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |
| Dementia/Alzheimer’s |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |

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| --- | --- |
| Today’s Date: |  |
| Signature: |  |