Donna Costa, DSHomMed, RNCP
140 Oxford Street East, Suite 309, London, ON N6A 5R9
www.donnacosta.com - info@donnacosta.com
(519) 858-0188

PATIENT INFORMATION FORMS

All information provided is held in the strictest confidence.

GENERAL INFORMATION:

Patient's Name:			**Occupation:**
Address:			
Phone:	**Home:**		**Work:**
Blood Type (if known):		**Height:**	**Weight:**
Date of Birth:	**Year**	**Month**	**Day**
Present M.D.			**Phone:**
Emergency Contact Person:			**Phone:**
Referred By:			

PATIENT INFORMATION:

Major complaints in order of importance to you:	**Since:**	**Cause:**

Can you trace the origin of any present condition to any particular circumstance (eg. accident, illness, incident, mental upset)?

Medications you are currently taking:	**Since:**	**Adverse Effects:**

Treatments / therapies you are currently following:	**Since:**	**Results**

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List any nutritional supplements you are taking: (vitamins, herbs, etc.)

Have you ever suffered from any of the following conditions? (Check those that apply.)

☐ Abortion
☐ Abscesses
☐ Alcoholism
☐ Allergies (list)
____
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Pressure
High/Low
☐ Cancer
☐ Chicken Pox
☐ Cold Sores
☐ Colitis
☐ Depression
☐ Diabetes
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Frequent Colds
☐ Gallstones
☐ Goitre
☐ Gonorrhea
☐ Gout
☐ Hay Fever
☐ Heart Disease
☐ Hepatitis
☐ Herpes Genitalia
☐ HIV
☐ Influenza
☐ Kidney Disease
☐ Leukemia
☐ Lyme Disease
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Mononucleosis
☐ Mumps
☐ Parasites
☐ Pelvic Inflammatory Disease
☐ Peritonitis
☐ Pleurisy
☐ Pneumonia
☐ Prostatitis
☐ Psoriasis
☐ Rheumatic Fever
☐ Rubella
☐ Scarlet Fever
☐ Sexual Abuse
☐ Skin Disease
☐ Strep Throat
☐ Sinusitis
☐ Stroke
☐ Sunstroke
☐ Syphilis
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid Fever
☐ Venereal Warts
☐ Warts
☐ Whooping Cough
☐ Worms
☐ Yellow Fever

Other Major Conditions / Major Injuries

Are there any of the preceding conditions after which you have never been totally well since? Which one(s)?

Operations:	**When:**	**Complications:**

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Recent Weight Change:			
☐ **Gain**	☐ **Loss**	**# of lbs.**	**Since:**
What exercise do you do and how much?			

How much of the following substances do you use?	
Tobacco	**Alcohol**
Coffee	**Recreational Drugs**

Are you currently under the care of a physician?		
Name	**For what condition**	**Treatment**

Have you been treated with homeopathy before?		
Homeopath	**For what condition**	**When**

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PATIENT INFORMATION FORMS

HEALTH HISTORY OF RELATIVES:

Check any of the following conditions present in your family

☐ Alcoholism
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Gonorrhea
☐ Gout
☐ Hay Fever
☐ Heart Disease
☐ Mental Illness
☐ Paralysis
☐ Pneumonia
☐ Skin Diseases
☐ Syphillis
☐ Tuberculosis

Include any other major complaints in your family history:

Relative	Age if alive	Age at death	Ailments and/or Cause of Death
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

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WAIVER

I, the undersigned, understand that Donna Costa is a registered practitioner of homeopathic medicine and a registered nutritional consultant, and that she is not a licensed medical doctor. As such, I acknowledge that it is my right and responsibility at any time throughout my treatment with Donna Costa to seek medical counsel and diagnosis from a medical doctor for any present and/or future condition(s) if so desired. I understand that I will never be asked by Donna Costa to discontinue or refrain from taking prescription drugs or to alter my dose in any way. I will not stop taking a prescription drug without first seeking advice from my medical physician.

I also reserve the right to terminate homeopathic/nutritional treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that, in choosing homeopathic treatment or nutritional consulting, I am exercising my right to choose an alternative method of treatment.

I hereby request and consent to the performance of treatment with homeopathic medicine and/or nutrition. As these modalities are not covered by existing government medical insurance plans, I agree to pay all fees incurred as presented in the current rate schedule below (rates are subject to change).

Service	Fee
Initial Consultation (for chronic conditions) – up to 2 hours	
Adults	$175
Children (age 10 and under)	$150
Follow-up Appointments – up to 45 minutes:	$65
Acute consultations	$35
Missed Appointments (if 24 hours notice not given)	$30
Remedy	$15

***Some extended health care plans now cover homeopathy and nutritional consulting ***

Please note:

- All fees are payable at the end of each consultation (cash or cheque).
- 24-hours notice is required to cancel or reschedule appointments.
- A fee of $30 will apply for missed appointments.
- A $10.00 shipping fee applies if remedy is mailed to the patient.
- An additional fee applies for in-home consultations (based on travel time & distance).
- Charges apply for responding to emails and/or phone calls over 5 minutes (based on $90/hour proportionate to time used, ie 20 minutes is $30).

“Thank You” Policy

If you refer another client to me for homeopathic care,
you will receive 50% off your next follow-up appointment fee.

______________________________ ____________________

Patient’s Signature Date

(If under 19 years of age, a parent or guardian must sign.)

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JOY OF HEALTH

TIMELINE FORM

The Timeline Form has been created to assist you in creating a history of your health and major life events through the years. Taking the time to complete the timeline and other intake forms will compel you to remember details that you may have forgotten and, in this way, you are more prepared for the initial consultation. This will also assist your homeopath to get the information she requires in order to make an accurate prescription. Please see the sample on the second page if you are having difficulty understanding this form.

Year	My Age	Major health or life event

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TIMELINE FORM

JOY OF HEALTH

SAMPLE

Year	My Age	Major health or life event
1958	BIRTH	
	3-8	Frequent ear infections
	15	Moved to a new city
	25	Married
	27	First child born; breech birth
	29	Second child born; normal pregnancy
1988		Car accident; Miscarriage
	33	Severe stress & work pressures
	37	Mother died in June; Father died in December
1998		Breast lump detected

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PRIVACY POLICY CONSENT FORM

Consent Declaration

My office understands the importance of protecting your personal information. To help you understand how I am doing that, I have outlined below how the office is using and disclosing your information.

This office will collect, use and disclose only necessary information about you for the following purposes:

- Types of Services: Homeopathic Medicine, Nutritional Consulting
- Newsletters, emails, seminars, Laughter Yoga sessions, and workshops

DISCLOSURE:

- To suppliers when shipping direct to patient.
- To patient's medical doctor(s) when required to confer or discuss patient's medical case, or with other health professionals regarding any medical reports or tests provided by the patient.

I will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

I am trained in the appropriate uses and protection of your information.

The privacy officer of this office is Donna Costa, DSHomMed, RNCP. If you have any questions regarding the Privacy Policy, please do not hesitate to ask.

Client Acceptance

I agree to this office collecting, using and disclosing personal information about me as set out above and in the Privacy Policy.

Date: ____

Printed Name: ____

Signature: ____