CLIENT REGISTRATION AGREEMENT

HILLTOP
HEALTH & HOMEOPATHY

CONSENT FOR HOMEOPATHIC TREATMENT

Homeopathy views health and well-being in a holistic manner. Consultations include a comprehensive intake that carefully evaluates symptoms on the mental, emotional, and physical level. Clients will be asked about their temperament, personal habits, likes/dislikes and unique outlook on life. Providing this information will allow the homeopath to understand each client as an individual, and to provide the most appropriate means of care. This view differs from most conventional approaches, which typically limit concerns to the individual symptoms and their treatment.

The goal of homeopathic treatment is to strengthen the constitution of the whole person, which often results in alleviation of symptoms and an overall increase in health.

CONFIDENTIALITY

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except when disclosure is required by law. (Disclosure may be required in circumstances such as: a reasonable suspicion of child or elder abuse or a reasonable suspicion that a client presents a danger to him/herself or others.)

CONSULTATION

I authorize discussion of my case notes with other homeopaths and/or health care professionals should assistance in remedy selection and/or case analysis be necessary (for me or my child) or if my best interest is served by such a consultation. In so doing, my right to privacy will be protected by withholding my name and all other identifying information.

CONSENT / HOMEOPATHIC SERVICE NOTICE

I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself/my child. I understand that Hilltop Health & Homeopathy is providing homeopathic care, and is not equivalent to care by a medical doctor. It is, therefore, recommended that I retain the services of my primary care physician for appropriate evaluations and check-ups for myself/my child. I further understand that Hilltop Health & Homeopathy does not diagnose, treat, or prescribe for any particular symptoms, diseases, or conditions. I understand that they will work to increase my (or my child's) general vitality and overall constitutional strength.

The practitioner states s/he is not a licensed physician or health-care provider; that homeopathic consulting services are not licensed by the state; that homeopathic consulting is not represented as nor intended to be a substitute for conventional medical diagnosis or treatment; and that it does not diagnose or treat specific pathological conditions or disease symptoms.

ACKNOWLEDGMENT

I understand homeopathy is a means of stimulating an individual's vital energy, with the aim of increasing the general well-being of the whole person through the use of homeopathic remedies. I understand that homeopathic services are not medical treatment and that the homeopath is not a licensed physician. I will not hold Randy Fruchter or Hilltop Health & Homeopathy liable for my overall health or well-being.

Name Date

Signature

HEALTH INVENTORY FORM

HILLTOP
HEALTH & HOMEOPATHY

Name:

Date:

Address:

DOB: **Age**:

Gender: **Height**: **Weight**:

Email Address:

Education: (**years completed**)

Primary Phone #:

Elem **HS** **Coll** **Voc** **Prof**

Secondary Phone #:

Occupation:

*__Emergency Contact__:

Employed: **Hours/Wk**: **Retired**:

Children:

*__If under 18, parent's Name/Address/Phone__:

Gender:

Ages:

Legal Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Domestic Partner

Living arrangement: ☐ Alone ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends

Are you currently receiving healthcare? If yes, where and from who? _____

Top 3 health concerns:

1. _____
2. _____
3. _____

Intensity of Symptom:

Very Mild 1 2 3 4 5 6 7 8 9 10 *Unbearable*

Very Mild 1 2 3 4 5 6 7 8 9 10 *Unbearable*

Very Mild 1 2 3 4 5 6 7 8 9 10 *Unbearable*

Date of last physical exam: _____

Date of last Blood tests: _____

Date of last colonoscopy _____

Date of last DEXA (bone density test) _____

HEALTH INVENTORY FORM

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Please check ALL that apply currently or previously and list approximate dates:

☐ Allergies ☐ Typhoid ☐ Cholera ☐ Food poisoning ☐ Worms ☐ Diarrhea ☐ Dysentery ☐ Blood clots ☐ Thyroid problem	☐ Measles ☐ German measles ☐ Chicken-pox ☐ Small-pox ☐ Mumps ☐ Whooping cough ☐ Prostate problems ☐ ED ☐ Low T	☐ Irregular menses ☐ PMS ☐ Miscarriage(s) ☐ Abortion(s) ☐ Endometriosis ☐ Fibroids ☐ Sickness during pregnancy ☐ Prolapse of uterus ☐ Breast lumps	**Circulatory:** ☐ High/Low Blood pressure ☐ Heart Failure ☐ Heart Murmurs ☐ Heart Attack ☐ Palpitation ☐ Giddiness ☐ Other ☐ Anemia ☐ Varicose Veins
☐ Asthma ☐ Cold-Fever ☐ Chill ☐ Pneumonia ☐ Pleurisy ☐ Rheumatic fever ☐ Scarlet fever ☐ Tuberculosis	☐ Major accident or injury to body or head ☐ Occasion of unconsciousness ☐ Major bleeding from any part of the body	**Venereal Disease:** ☐ Chlamydia ☐ Condylomata ☐ Gonorrhea ☐ Herpes ☐ Syphilis	☐ Kidney Stones ☐ Nephritis ☐ Diabetes ☐ Prostate ☐ Cancer ☐ Prostatitis ☐ AIDS
Operations: ☐ Tonsils ☐ Abdomen ☐ Appendix ☐ Hernia ☐ Uterus ☐ Renal stones ☐ Gallstones ☐ Phimosis ☐ Hydrocele ☐ Cataract ☐ Lasik ☐ Cosmetic **Mode of Anesthesia:** ☐ General ☐ Local **Antibiotics:** ☐ Never ☐ Less than once/yr ☐ More than once/yr ☐ Vaccine reaction	☐ Diphtheria ☐ Septic ☐ Tonsils ☐ Adenoids ☐ Recurrent infections ☐ Bronchitis ☐ Colitis ☐ Cystitis (Bladder) ☐ Eosinophilia ☐ Otitis Media (Ear) ☐ Pelvic infection ☐ Sinusitis ☐ Yeast Infection ☐ Candida	**Skin diseases:** ☐ Acne ☐ Allergy ☐ Boils ☐ Carbuncles ☐ Eczema ☐ Fungus ☐ Herpes ☐ Hives (Urticaria) ☐ Moles ☐ Ringworm ☐ Scabies ☐ Ulcers on body parts ☐ Warts	☐ Serious shock ☐ Grief ☐ Disappointments ☐ Fright ☐ Mental upset ☐ Mental Illness ☐ Anxiety ☐ Depression ☐ Nervous breakdown ☐ Panic attack ☐ Psychotherapy ☐ Suicide attempt ☐ Alcohol/Drug problems ☐ Steroid use
	☐ Malaria ☐ Jaundice ☐ Any Liver, Spleen or Gall bladder disease ☐ Hepatitis ☐ Malnutrition ☐ Rickets ☐ Arthritis ☐ Gout ☐ Rheumatism ☐ Backache/problems	☐ Insomnia ☐ Nightmares ☐ Sleep disorder ☐ Anorexia/bulimia ☐ Binge eating ☐ Overweight ☐ Chemical Sensitivity ☐ Periodontal disease ☐ Glaucoma ☐ Hearing problems ☐ Hemorrhoids ☐ Hernia ☐ Phlebitis ☐ Varicose Veins	☐ Chronic fatigue ☐ Chronic headaches ☐ Migraines ☐ Numbness ☐ Cramps ☐ Fits ☐ Neurological problems ☐ Seizures/epilepsy ☐ Convulsions ☐ Polio ☐ Paralysis ☐ Meningitis ☐ Any Lumbar Puncture

PAST HISTORY OF ILLNESSES, HEALTH CHALLENGES AND MEDICAL/SURGICAL PROCEDURES

Hospitalizations:	**Surgeries:**
Serious Illnesses & Injuries:	**Accidents, Traumatic Injuries, Broken Bones:**

HEALTH INVENTORY FORM

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WOMEN Only

Date of last menstrual period:
Date of last pelvic exam:
Date/results of last pap smear
Ever had abnormal pap smear?
DES exposure
Sexually Transmitted Disease
History of sexual disease
Frequent yeast infections
Frequent bladder infections
Vaginal discharge
Age period began
Regular periods: Yes ☐ No ☐
Flow: Heavy ☐ Medium ☐ Light ☐
Length of cycle _____ Days of Flow _____ .
Spotting ☐ Cramps ☐ PMS ☐
Endometriosis ☐ PID ☐ Fibroids ☐
Ever used Birth Control pills?
How long for?
How long ago?
Present Birth Control
Change in sex drive
Painful intercourse
Pregnancies (number)
Childbirth (number)
Complications
Miscarriages (number)
Abortions (number)
Impaired fertility
Have you ever had a hysterectomy?
Age at Menopause
Vaginal dryness
Hot flashes
Do you do self breast exams?
Mammograms (number)
Date of last Mammogram

MEN Only

Date of last Prostate Exam
Prostate enlargement
Change in force of urine stream
Difficulty starting urination
Do you do self testicular exams?
History of undescended testicles
Pain / lump in scrotum
Discharge from penis
Painful intercourse
Difficulty with erections
Change in sex drive
Impaired fertility
Sexually Transmitted Diseases
History of sexual abuse

Worry and Anxiety: Do you have particular issues that worry you? How does this impact your life?

Healthy relationships: Do you have a supportive family/community?

Unhealthy relationships: Have you been a victim of domestic abuse or troubling relationships?

Anything else you wish to discuss?

HEALTH INVENTORY FORM

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Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe: _____

_____

_____

Do you exercise? Yes _____ No _____ What Type? _____

Frequency? _____ Are you happy with amount? _____

Personal Habits:
Please indicate which substances, if any, pertain to you. N = use NOW P = used in the PAST

Substance	N/P	How Much?	How Long?
Tobacco			
Alcohol			
Rec Drugs			
Coffee			
Black Tea			

Substance	N/P	How Much?	How Long?
Soda			
Diet Soda			
Artificial Sweeteners			
Refined Sugar			
Processed Food			

Do you need guidance/support with a healthy well-balanced diet? _____

Do you have specific spiritual practice? Y_____N_____ If so, please describe it:_____

LIFE CHANGES

In the past year, what changes have occurred in your:

Personal life:
Family life:
Social life:
Work life:
Sex life:

HEALTH INVENTORY FORM

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FAMILY HISTORY:

	Age	If deceased, cause of death
Mother		
Father		

Siblings	Age	Deceased?

Check (double click box and select 'checked') items that apply to blood relatives and list relationship:

- ☐ Alcohol/drug problem _____
- ☐ Allergy/asthma _____
- ☐ Anemia _____
- ☐ Arteriosclerosis _____
- ☐ Arthritis _____
- ☐ Binge eating/bulimia _____
- ☐ Bleeding problem _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy/seizure _____
- ☐ Heart disease _____
- ☐ Skin disease _____
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Kidney disease _____
- ☐ Liver disease _____
- ☐ Mental illness _____
- ☐ Obesity _____
- ☐ Stroke _____
- ☐ Suicide _____
- ☐ Thyroid disease _____
- ☐ Tuberculosis _____
- ☐ Ulcer _____
- ☐ Syphilis _____
- ☐ Gonorrhea _____

Please list all prescription and over-the-counter medications you are currently taking:

Medication	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

Supplement	Dose	Date Started

Please list any severe or life-threatening allergies (include method of testing): _____

CREDIT CARD AUTHORIZATION FORM

HILLTOP
HEALTH & HOMEOPATHY

Please use this form if you plan on credit card payment. We can also accept PayPal and are open to other payment arrangements.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CREDIT CARD INFORMATION

Card Type: ❍ MasterCard ❍ VISA ❍ Discover ❍ AMEX

❍ Other_____

_____

Cardholder Name (as shown on card)

_____

Card Number CVV/CVV2 (3 digit code)

_____

Expiration Date (mm/yy) Cardholder ZIP Code (from credit card billing address)

I, _____, authorize **Hilltop Health & Homeopathy** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____

Customer Signature Date