Caruso Clinic
Guelph Ontario

Local 519 827 9237
Toll Free 1 866 249 5755

www.carusohomeopathy.com

Please read this introduction before filling in the intake forms.

Dear Client,

We are honoured that you are willing to trust us with the care of yourself or your family. What we offer in terms of service are homeopathic medicines, herbs, nutritional and diet guidance. We offer a holistic approach to health care. You have decided to seek natural treatment to improve your health. The information asked of you will help us to find the best possible remedies for your unique condition.

Remedies are based on your symptoms and it is important to know the details of your illness. Homeopathic remedies are based on symptoms rather than the disease name. These symptoms are based on your past, family history and your particular constitution. Thus we ask a lot of questions to have this information ahead of time to prepare us for your visit. Please set aside around 20 minutes to fill in this form as best you can. You may want to write on a separate sheet a seven day diet diary recording all that you eat and drink over this period. It will help us to help you better. For children, please fill in the information in the child's name and health issues.

Please fill this in as truthfully and frankly as possible. Small details that you may see as irrelevant may help us in finding your remedies better as not two people are exactly alike. If you are unsure of an answer, ask a family member. If you find a question doesn't pertain to you, leave it blank.

Please note we have strict confidentiality policies. Any information shared with us in this form or in person is completely confidential. Thank you for your interest in the clinic. It is my honour to be of service to you and help you on the road to health.

Heather Caruso

Part One Contact Information

Name: _____ Date of Birth: M/D/Y_____
First and Last

Sex circle one Male Female

Please enter parent's names: Mother: _____Father_____
Address:

_____
Number, Street name, apt number, City and Postal Code

Phone number: Home_____ Work _____Cell_____

Email address _____Circle one, email is Mom's or Dad's

Would you like to join our free email health newsletter list? Please choose: Yes No

What or who referred you to the clinic? E.g, internet, yellow pages, friend's name etc.

_____

Part Two: Current Health Status

Please list your child's main complaints in order of importance to you with a detailed history of when it started and any associated troubles that have started since.
E.g. Asthma, since age 4 after a bout of pneumonia, today I have chronic bronchitis and need puffers daily
_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any guess or fact as to the origin or the cause of any of your child's complaints? List anything that has happened that he/she has never felt well since? For example, stress, an accident, illness, shock, diet or exposure to something?
_____
_____
_____

Please list any medications your child currently takes and the approximate dates he/she started them.

_____

_____

_____

_____

_____

Please list any vitamins or supplements with the brand name and dosage your child currently takes. E.g. Swiss brand acidophilus, one capsule daily.

_____

_____

_____

_____

_____

Part Three: Past Health Status

In the past has your child taken any medications or supplements long term (more than three months)? If yes please list them. Please also note any ill effects he/she had from them if any.

_____

_____

_____

Have your child had any surgeries or operations? If yes, please list them, date and for what purpose?

_____

_____

_____

_____

Family History, Pregnancy and Conception

Any family history of addiction? Yes No If yes what type: _____

Was the conception planned? Yes No

Any drugs or medications used during pregnancy? Yes No If yes what type: _____

_____

Any maternal stress, (sadness, grief, anxiety) during pregnancy? Yes No If yes, what type:

_____

_____

How was the delivery, any problems during delivery? Yes No If yes what type: _____

_____

Circle if applicable:

-epidural -anesthesia -induced -breech baby -low apgar score -low birth weight -premature delivery -cord around neck

Was the child breast fed? Yes No If yes for how long? _____

Did the child receive all their mandatory vaccinations? If yes please bring along their vaccination card
Any ill effects after vaccination? Circle one Yes No If yes, please describe;

_____

_____

In the first five years of life, did your child receive any surgeries or medications? If yes, please list them with the approximate date:

_____

_____

_____

_____

_____

_____

Previous Illnesses

Please mark down any illnesses your child has had. Please mark them, with their age that it happened, duration, whether they made a full recovery. For example, influenza, age 3, recovered no, treatment tamiflu

Disease	Age	Duration	Recovered?	Treatments

Part Four: Family History

Relationship	Alive or Deceased	Age	Diseases suffered from	Cause of Death if Any
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Brother				
Sister				
Father				
Mother				
Paternal Aunt				
Paternal Uncle				
Maternal Aunt				
Maternal Uncle				

Did any of your relatives have similar troubles to your child?

_____

Part Six: Lifestyle Information

Does your child follow any special diets? Yes or no, if yes please indicate type for example, lacto ovo vegetarian, vegan, high protein, candida diet, gluten free, allergy diets

_____

Does your child avoid any foods that may bother him or her? If yes, please list them and their effect

_____

_____

Does your child exercise? If yes, how often and what type?

_____

Have your child's weight changed in the past year? If yes, please indicate whether he/she has lost or gained weight and the amount_____

Do either of your child's parents smoke? If yes, what do you or your spouse use? Tobacco, cigars, marijuana and how many and how often

_____

Does your child drink pop, tea or coffee? Please indicate the quantity, frequency and which one

_____

_____

Part Seven: Regime Compatibility

Regime and Lifestyle Compatibility

This sheet is to help determine what regime would is compatible with your desires and lifestyle. Please check the following that you are interested in

☐ Optimizing my health through all means possible, whatever it takes. (diet, supplements and testing)

☐ Optimizing my health through supplements and testing, I am not willing to change my diet

☐ Optimizing my health primarily through diet and little supplementation, as necessary

☐ Optimizing my health only through diet only

☐ Optimizing my health by using only one single homeopathic remedy

Please check the amount of time you have to dedicate to your child's health

☐ Whatever it takes	☐ 1 hour per day	☐ ½ hour per day	☐ 15 minutes per day

Testing

Testing is not completely necessary, however, three tests are very informative about one's health status and can help a person get on the right track. Food sensitivity testing, darkfield microscopy for nutritional imbalances and hair mineral analysis to detect the body's mineral state and heavy metal toxicity

☐ I am interested in all testing available to me to optimize my health

☐ I am interested only in the tests my practitioner strongly suggest to me

☐ I am not interested in testing

Diet Diary~ Three Day Journal

Date:_____

Check # of 8 ounce glasses of water: 

TIME	QUANTITY	FOOD/ DRINK	HOW FELT BEFORE?	HOW YOU FELT AFTER?
7am	2 cup coffee, 2 ounces of cream	Coffee and cream	Good	Stomach ache and loose stools, irritable

How you felt can be both physical or emotional, for example, exhausted, stomach aches, hives, headache, irritable, anxiety, happy, sinus congestion, caused more food cravings.

Date:_____

Check # of 8 ounce glasses of water: 

TIME	QUANTITY	FOOD/ DRINK	HOW FELT BEFORE?	HOW YOU FELT AFTER?
7am	2 cup coffee, 2 ounces of cream	Coffee and cream	Good	Stomach ache and loose stools, irritable

Date:_____

Check # of 8 ounce glasses of water: 

TIME	QUANTITY	FOOD/ DRINK	HOW FELT BEFORE?	HOW YOU FELT AFTER?
7am	2 cup coffee, 2 ounces of cream	Coffee and cream	Good	Stomach ache and loose stools, irritable

Authorization for Treatment and Acceptance of Fees for Caruso Homeopathic Clinic

I hereby attest to the following:

1. That I am here on this and any subsequent visit(s), solely on behalf and not as an agent for any federal, provincial, municipal agency or on a mission of entrapment or investigation.
2. I understand that, Heather Caruso is a holistic nutritionist and homeopath and not a medical doctor and not I am not visiting her for a diagnosis of a medical condition or treatment procedures. Homeopaths treat people based on symptoms that a person has, not a disease name. If I have any health problem, health condition or disease, I am now being advised to continue a relationship with my medical doctor and not to delay any medical treatments. I recognize that any treatment prescribed is not designed to prevent or cure any physical or mental disease/disorder. I am here to learn how to do this for myself.
3. The consultation and services provided by Caruso Homeopathic Clinic are restricted to building wellness via natural methods, diet, homeopathy, herbs and supplements.
4. A registered orthomolecular health practitioner, holistic nutritionist and homeopath are not licensed to diagnose and treat disease. Many doctors leave nutrition and holistic methods out of their consultations because they don't have indepth training and time to spend with each patient. This is where we come in, we are able to do is advise people on which diets and natural regimes may build health. If as a consequence people feel better physically, emotional and disease lessens from our treatments, so be it.
5. Nature heals the body when it is given proper nutrients rather than pinpointing a disease name. The body is normalized when natural foods and supplements are taken in place of toxin producing substances. We believe it is not important to name diseases, but improve the health of the individual by getting back to the basics of healthy habits through proper nutrition, exercise and nature.
6. **When cancelling your appointment please give us a full 24 hours notice during regular office hours Monday to Friday, full fees apply to missed appointments without this notice.** We are a small business, we dedicate a lot of time to each case, we have other patients who would like your appointment time. Thank you for your respect concerning this policy.
7. **For acute illnesses, for telephone or skype consultations when you cannot be present and for supplement re-orders and missed appointments,** we require a credit card on file. Please include a credit card, with expiry and three digit code. Please note we will not use your credit card without giving you notice.

   Credit card number and type:_____Exp: _____

   CVV code:_____

Basic Fees for Service

Fees are due when service is rendered unless otherwise arranged.

Initial visits are adult are $225.00 plus HST and children, students and seniors are $195.00 plus HST.

Follow ups are $85.00 for adults and children, students and seniors are $65.00 plus HST.

Acute visits are 40.00 for 20 minutes, these are for people with acute issues, like symptoms of colds, flu, ear aches etc.

Additional Notes on Fees

For follow ups after 3 months, there is an additional $10.00 for the initial repeat visit to thoroughly review the file.

After 3 years without a follow up, more time is required for proper case taking to ensure the highest amount of care and an initial consultation is required.

File review, for reviewing client files from other doctor's or 10 pages or more of lab tests, $65.00

Phone calls, emails or texts, in between visits, there is no charge for questions about dosing of your remedies. For all other health inquiries in between visits, the charge is $20.00 per 10 minutes.

Any other fees for tests or medicines, will be discussed and the prices will be shared as required.

Declaration of Acceptance

I have read the above explanation of the type of treatment offered by Caruso Homeopathic Clinic. I understand the above methods of treatment and want this type of treatment for my child. I am not expecting any other type of treatment than what was described here and abide by these conditions set forth in this authorization. I am signing this voluntarily and not under any duress at this time.

I confirm that I have been informed of the standard charges and missed appointment policy. I consent to being charged for missed appointments without 24 hours notice during business hours.

_____ Printed name of child

_____Signature of parent or guardian

_____ Date