# Bespoke Births (NZ)

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# Homeopathic Fertility Consultation Intake Form (if you are coming to see me as a couple, please both complete this intake form)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Postal code

Telephone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:

**Major Complaints in Order of Importance For You:**

|  |  |  |
| --- | --- | --- |
| Complaint | Since | Causes |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Which Medications Are You Currently Taking?**

|  |  |  |
| --- | --- | --- |
| Medication | Since | Adverse Effects |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**What Other Treatments or Regimes Are You Currently Following?**

|  |  |  |
| --- | --- | --- |
| Treatment or Regime | Since | Results |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Which Of The Following Conditions Have You Had? Please circle**

Acne Allergies Anemia Anxiety Arthritis Asthma

Cancer Chicken Pox Cold Sores Depression Diabetes

Epilepsy Gall Stones Goitre Heart Disease Hepatitis Herpes Influenza Kidney Disease Leukemia

Liver disease Measles Migraine Miscarriage Mononucleosis (Glandular fever) Mumps

Pelvic Inflammatory Disease PCOS PMS PMDD Rubella Stroke Thyroid issues

**Any Other Major Conditions?**

**Are there any of the preceding conditions after which you have not been totally well again?** Yes/No

**Which Ones?**

(Women)Age of first Menses (Period):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women)Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Age of Perimenopause/Menopause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are You Currently Under the Care of a Physician(s)?**

Physician For Which Condition/s? Treatments

**What Major Operations Have You Had?**

|  |  |  |
| --- | --- | --- |
| Operation | When | Complications |
|  |  |  |
|  |  |  |
|  |  |  |

**What Major Injuries Have You Had?**

|  |  |  |
| --- | --- | --- |
| Injury | When | Complications |
|  |  |  |
|  |  |  |
|  |  |  |

**Which of the Following Substances Are You Using?**

Tobacco\_\_\_\_\_\_\_\_\_\_\_\_Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_Coffee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Recreational Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many times per day?**

**Anything else you would like me to know about?**

**Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:**

Alcoholism Allergies Anxiety Arthritis Asthma Cancer Depression Diabetes

Epilepsy Heart Disease Kidney issues/disease Liver disease Migraine Miscarriage PMT PMDD Stroke

|  |  |  |  |
| --- | --- | --- | --- |
| Relative | Age if alive | Age at death | Ailments |
| Mother |  |  |  |
| Father |  |  |  |
| Brothers |  |  |  |
| Sisters |  |  |  |
| Children |  |  |  |
| Maternal Grandmother |  |  |  |
| Maternal Grandfather |  |  |  |
| Maternal Aunts/Uncles |  |  |  |
| Paternal Grandmother |  |  |  |
| Paternal Grandfather |  |  |  |
| Paternal Aunts/Uncles |  |  |  |

**Is there any other information that I would need to know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Professional Waiver**

**PLEASE READ THE FOLLOWING CAREFULLY** (if under 18years of age, a parent or guardian must sign.) I, the undersigned, understand that Angela Ivory (Dip Hom) is a Homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Angela Ivory, I am exercising my right to choose an alternative method of treatment through which to address my total health. I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Angela Ivory/Bespoke Births (NZ) which will provide me with relevant health information/newsletter, upcoming events. I understand that I can unsubscribe to these e-mails at any time.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_