Center Homeopathy L.L.C.

Imam Toufique D.Hom

Classical Homeopath

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BEFORE FILLING THE FORM, PLEASE TAKE A FEW MINUTES TO READ FOLLOWING FIRST

Dear Client

Thank you for considering homeopathy for your holistic health needs. I am here to help you with the best possible homeopathic remedy for the health condition you are here for. In order to do that, we need your sincere help and cooperation. HOMEOPATHIC MEDICINE IS SELECTED PRIMARILY BASED UPON THE SYMPTOMS YOU GIVE US. If you provide us with all the symptoms you are experiencing, there is a very good chance that we can select the best suitable medicine for you. We must understand you as an individual! This includes your past and family history, your reactions to various social and environmental factors, your past illnesses/health issues, and most importantly your mental changes and condition(s). Please note, that the mere mention of a complaint does not suffice for a good prescription of a medicine.

In order to find out about you, we have come up with a series of questions to evaluate you as an individual. Please note that each of these questions have significance and certain meaning to us. No question here is useless, even if a question might sound 'funny' or 'odd' or 'useless'. Therefore, please be open to these questions, have an open mind while you are answering these questions. Please read each question carefully, think before writing down answers, consult with your friends and relatives, if you need help. Anything you write down, anything you discuss during your consultation will absolutely remain confidential.

CONFIDENTIAL

Name_____ Birth Date_____ Age_____

Home Address_____ Phone_____

City, Zip_____ Phone_____

Work/Business Address_____ Phone_____

e-mail_____

Sex M F

Occupation_____ Employer_____

Marital Status a. married b. never married c. divorced d. widowed

Living situation: a. alone b. friends c. spouse

Number of children(if any)_____

Employment status a. employed b. house wife c. full-time d. part-time e.unemployed

Person to be contacted in case of emergency_____

address_____ Phone_____

List of member(s) of household

Name	Age	Relationship

I……State all information given above is to the best knowledge, all true and correct. I understand Imam Toufique D.Hom. is not a medical doctor and homeopathy is not state licensed in California. (There is no License in the State of California see SB577)

Signed.....Date.....

Remarks(For Office Use):

Clinic Policies

California Senate Bill SB-577, was signed by the governor in September 2002, has profound implications for the practice of alternative forms of health care in California. SB-577 enables non-licensed alternative and complementary health care practitioners to provide and advertise their services legally. However, they must also comply with certain requirements specified within the bill.

What does Senate Bill SB-577 mean for you, the client?

SB-577 gives you access to alternative and complementary health care practitioners. You must be given information about the nature of treatment and the practitioner's qualifications. Feel free to ask a practitioner any question you might have about your treatment. Check to see if your practitioner has been certified by a professional membership society. In addition, tell your doctor about any alternative treatment you are pursuing. You can also request that your licensed and non-licensed health care providers communicate with each other and work collaboratively to meet your health care needs.

SB-577 helps to protect you. SB-577 requires non-licensed alternative health care practitioners to follow certain guidelines and restrictions. Below are the things that alternative practitioners are NOT allowed to do:

- Perform any form of surgery or any procedure that punctures your skin or harmfully invades your body.
- Use X-ray radiation.
- Prescribe prescription drugs or recommending that you discontinue drugs that were prescribed by a licensed physician.
- Set fractures.
- Treat wounds with electrotherapy.
- Put you at risk of great bodily harm, serious physical or mental illness, or death.
- Imply in any way that they are licensed physicians.

In addition, non-licensed alternative practitioner MUST DO the following things:

Provide you with a statement, written in plain language that includes the following information:

- That they are not a licensed physician and that their services are not licensed by the state;
- A brief and clear description of the kind of services they provide and the reasoning behind it.
- A description of their education, training, and experience.

Client disclosure: Please read carefully!

Welcome to my practice, I am a practitioner of homeopathy, I am not a licensed physician, nor are homeopathic services licensed by the state of CA. The idea behind homeopathy is that it is a natural system of medicine that uses specially prepared (FDA regulated since 1938) highly diluted doses of substances to stimulate the body's own healing mechanism. As a practitioner of homeopathy, I will provide you with the followings kinds of services:

Initial homeopathic consultation, selection of a homeopathic remedy and follow-up consultations to evaluate treatment response.

I have been practicing **homeopathy** since **2018**. My training and education is described below:

I have a Bachelors of Science in Information Systems and management, Diploma in Homeopathy. I lecture on Homeopathy study groups and on-line courses.

In order to use my services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. I will keep the original in my records for at least three years.

My method of treatment is **homeopathy**, a complementary healing art, in the State of California, under Sections 2053.5 and 2053.6 of California's Business and Professions Code, I can offer you these services, subject to requirements and restrictions that are described fully on this document.

If you have any concerns about the nature of your treatment, please feel free to discuss them with me. I recommend that you inform your medical doctor that you are receiving **homeopathic** treatment.

Acknowledgement and Consent to Receive Services :

I have read and understand the above disclosure about the homeopathic treatment offered by Imam Toufique. I understand that he is not a licensed physician and that his services are not licensed by the State of California. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered by Imam Toufique and agree to be personally responsible for the fees of Imam Toufique in connection with the services provided to me. I understand the office policies, cancellation polices and phone/email consult fees.

Any controversy or claim arising out of, or relating to, this agreement, first need to be addressed with Imam and his clinic staff, if that issue was not settled by the clinic, then it shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction. The client will pay for the arbitration fees.

Fees and Clinic Policies

- Fees: First consultation and two follow-ups are highly recommended to help select a proper homeopathic remedy. It is very important for any chronic health issues. First consultation take about 2 hours, and follow-ups are usually 45 minutes. *Payment must be made at the time of or prior to consultation.*
    - Intake consultation fee is $180.00. Subsequent follow-ups, as needed, are $65 each.
    - Remedy cost is between $10 - $45, and shipping cost is $7. If there are special ordered remedies, you will be notified about the additional cost.
    - A returning case after 6 months is considered almost a new client(as many things might change during this period), therefore, a re-take of the case would cost $160.
- Payment: Fees must be paid in full before the service. Accepted payment methods are Cash, Zelle, Venmo or PayPal.
- Canceled and missed appointment policy: A 48-hour cancellation notification is required, your appointment can be changed or canceled at no charge, before 48-hours of your appointment. If you miss an appointment and cancel less than 48-hours notice, you will be charged for it.
- Time: I book appointments just one person at a time. Your time is valuable to me. Please be courteous, if you can't make an appointment, please give me 48-hours notice, otherwise there is a charge for the missed appointment, which is the same as the fee.
- Phone/email consults: If you need an acute consult in-between, the fee is $45 for each 20 minutes. This is not for follow up consults. If a difficult acute I may need more then 20 minutes to do research.

Signed:_____ Date: _____

Print name: _____

Indicate capacity to sign if other than client _____ (Client/parent/conservator/guardian)

Consent to video and/or audio record consultations

Homeopathic interviews are very detailed and it helps in a great deal record the interview for reference purposes and inter-staff consultation purposes. This information is strictly confidential and never published in any types of social media.

If you consent your interviews video/audio taped, please sign and date below.

*Signed:*_____ *Date:*_____

Print name: _____

*Indicate capacity to sign if other than client*_____*(client/parent/conservator/guardian)*

Part 1: Description of your main problem/compliant(s)

In this part, please list your main complaint(s), other associated troubles. And detailed history of present illness. The onset and course with dates.

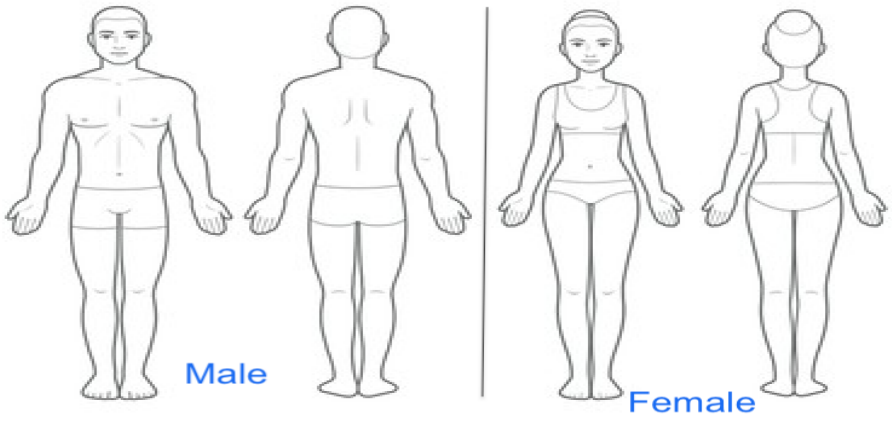
1.a: What are your complaints? Be as detailed as possible. If you need more room, you can add a sheet of paper.

1.b: Since when are you having the complaints?

1.c: Can you find/trace the origin of your present illness to any particular circumstance, accident, injury, incident, shock, grief, or mental upset? (e.g. shock, worry, grief, issues/errors in diet, physical or mental overexertion, exposure to cold/heat, exposure to chemicals, etc. .)

1.d. In the diagram below, circle the exact location of sensation, pain, and eruption. You can write down anything in the space provided below in detail.

Sensation: Express the type of sensation or the pain that you get in your own words. Express the sensation or pain as it feels to you. For example, throbbing pain in my neck, cutting pain in my legs. Do the best you can please.



Part 2: Past illness, medical history, developmental history. It also includes details on the medical history of family members.

2.a: Stimulant/Alcohol/herbs use:

Do you use any of the following:

Herbs_____

Remarks(For Office Use):

Coffee(number of cups)_____

Alcohol(occasional/heavy/moderate)_____

Aspirin(how many)_____

2.b: List all your medications below(if any). List all your supplements below(if any). Write the dosage with each medication.

_____

_____

2.c. Have you ever been hospitalized? If so, please fill out the following section.

2.d. Past and family history

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, affecting us much more than we imagine. Homeopathic treatment takes into account all these details of the past and thus removes all weak points. Your body is strengthened. It is therefore necessary for us to know about all the ailments you have suffered from in the past and treatments you have taken.
In the list below, circle the names of ALL major illnesses suffered so far and on the next page give their relevant details.

Part 3: Factors that affect your health and well being. What affects you day-to-day has a significant meaning to get a successful prescription of your medicine.

3.a. What is your daily diet like? Can you briefly explain?

3.b. How is your appetite?

3.c. When are you hungry?

3.d. What happens if you have to remain hungry for long?

3.e. Do you have a habit of eating fast?

3.f. How much thirst do you have?

3.g. How frequently do you drink and how much?

3.h. Do you feel any change in your taste and feeling in your mouth?

Remarks(For Office Use):

3.i. The following section is very important for us. Please add one plus sign (+) for like/dislike, two plus signs (++) for stronger like/dislike, and three (+++) for strongest like/dislike.

	like	dislike	disagree
salty			
salt extra			
spicy			
spicy and salty			
salty and sour			
salty, sour and spicy			
bitter			
sour			
sweet			
exotic			
bread			
butter			
cheese			
eggs			
chicken			
red meat			
pork			
lamb			
fish			
fatty food/fried food			

	like	dislike	disagree
onion			
tea			
cabbage			
coffee			
curds			
fruits			
warm food			
cold food			
warm water			
cold water			
iced water			
iced tea			
ice			
ice-cream			
smoked flavor			
anything else			

3.j. <u>STOOL</u>

A. Do you have any problem regarding your stools?

Remarks(For Office Use):

3.k. URINATION & URINE

A. Any problem about urine? Any strong smell? Like what?

B. Any difficulty about the flow Slow to start, interrupted, feeble, dribbling etc.?

C. Any involuntary urination? When?

3.l. SEXUAL SPHERE (GENERAL)

A. Any excessive indulgence in sex in past and present?

B. Any effect on your health?

C. How do you feel after sexual intercourse?

D. Any particular feelings or symptoms appear before, during or after sexual intercourse?

E. Do you suffer from any sexual disturbance?

F. Any habits like (masturbation etc.) in past as well as present? How often?

G. Did you suffer from any sexually transmitted disease?

H. Did you have increased desire or decreased desire for sex?

I. What is the method you use for family planning (contraception)?

3.m. FOR MEN

A. Any difficulty in erection?

B. Wanted erection? Unwanted erection?

C. Weak erection? Failing erection? Describe.

D. Any other trouble in sex? Describe in detail.

E. Any complaints of nightfall or seminal emissions?

3.n. FOR WOMEN

Menses : How are the periods; regular or irregular? Please explain all the issues.

Remarks(For Office Use):

3.o Obstetrics History

A. Please list all your pregnancy details.

The following list of factors are with great importance to homeopathy. These are lists of factors that you are exposed to, deal with, experience upon, etc. . in a particular way. Please write down in what way you are affected by each of the following factors. You might feel better or worse - one way or another, in each of these factors. Please only indicate factors which have a distinct or important effect on you - not those with only a slight (or very mild, or extremely mild) effect on you.

For example, let's take the factor, "cold" weather. If you feel extremely unusually uneasy during cold weather, write down "extremely uneasy" in that section.

Another example, take the factor "sun". Suppose by going in the sun you get a headache
then write "Headache" opposite to "Sun".

In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to "lying on the back" write "Asthma becomes worse".

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause headaches but make you feel better in general. If this is so, please mention this difference clearly.

As mentioned before, the following section has the highest importance. So, please do not hurry up to fill in this section. Take your time, think before you answer each of the following factors. We appreciate your time with this section!

Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunderstorm	
Covering	
Warm bath	

Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Shaving	
Moonlight	
Opening mouth	
Sticking tongue out	

Remarks(For Office Use):

Sun	
Lying with head low	
Sitting	
Sitting erect(or straight up)	
Standing	
Looking up	
Looking down	
Noise	
Sudden Noise	
Loud Noise	
Music	
Loud Music	
Light	
Strong smells	
Light	
Strong smells	
When constipated	
Before urine	
After urine	
During urine	
Before menses	
During menses	
After menses	
After sweating	
When fasting	
After eating	
Before important engagement	
Before exams	
When angry	

Smoking	
Hanging limbs	
Raising the arms	
Near Sea	
Stretching	
Swallowing	
Listening other talk	
Listening others sing	
Vomitting	
Yawning	
Moving the eyes	
Opening eyes	
Closing eyes	
Getting feet wet	
Over eating	
Working in water	
Fanning	
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding in car, bus.	
Lying	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	
Drinking	
After sexual intercourse	
Right before sexual intercourse	
Dust	

Remarks(For Office Use):

When excited	
When worried	
When sad	
After weeping	
Consolation/sympathy	
In a crowd	
In closed room	
In a stuffy room	
When thinking of illness	
Full Moon / new moon	
Morning	
Afternoon	
Evening	
Night	
Bathing (with cold water)	
Bathing(with luke warm water)	
Bathing(with hot water)	
Draft air	
Moist air	
Hot air	
Warm air	
Biting or chewing	
Blowing noise	
when alone	
In company	
Physical exertion	

Smoke	
Touch	
Pressure	
Massage	
Tight clothes	
Before sleep	
During sleep	
After sleep	
After afternoon nap	
Loss of sleep	
Before sleep	
During sleep	
After stools	
During stool	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	

Part 4: About your mental and your emotional state

In order to understand your emotional and intellectual nature, we will be asking certain questions. Answer them freely, carefully and completely. This information will help us in giving you the correct medicine. Also such a medicine will help improve your mental makeup.

1. Are you anxious? About which matters?

Remarks(For Office Use):

2. Are you scared of anything? If so, please explain, with as much details possible.

3. Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc?

4. Are you doubtful or suspicious? Of what?

5. What are you jealous about? Of whom? From what symptoms do you suffer when you get jealous?

6. Generally how would you describe yourself as, slow / medium / fast pace?

7. What would you like to change about your personality?

8. How long do you remember hurts caused to you by others?

9. Are you revengeful?

10. Are you proud of anything? What are you proud of? Does your pride get easily hurt?

11. Do you ever become suicidal? When? If so, in what manner do you contemplate to end your life? Even then, are you afraid of dying?

12. When are you cheerful?

13. Are you sexual-minded? Do you think of any unwanted thoughts any time? What are they?

14. Do you have any imaginary sensations or fears?

15. How is your memory? For what is it poor? E.g. names, places, faces, what you have read, etc.

16. Are you easily irritated?

17. What makes you angry? Do you get violent?

18. What bodily symptoms do you develop when angry? E.g. trembling, sweating, etc.

19. Do you like company? Or like to remain alone?

Remarks(For Office Use):

20. How seriously are you affected by disorder and uncleanliness in your surroundings?

21. What are the greatest grieves that you have gone through in your life?

22. What are the greatest joys that you have had in your life?

23. What activities do you deeply like?

24. Are there any matters which you deeply dislike?

25. In your opinion, which aspect of your mind and moods are not agreeable to you, that in spite of your awareness and maturity, you are unable to change?

26. In your opinion, which aspect of your mind and moods are not agreeable to you, that in spite of your awareness and maturity, you are unable to change?

27. How does the future look to you?

28. When you are free, what thoughts come to your mind?

29. Are you worried or unhappy over any personal, domestic, economical, social or any other conditions? If so, describe in detail.

30. Have you had any bereavements in your life?

Part 5: Sleep and Dream

Information About Your Sleep

A. Describe your sleep pattern with as much detail as possible. Do you sleep on your back? Or on the side? Or on your abdomen?

B. Are you able to sleep in any position? Does any sleep position make you uncomfortable? In which position you can't sleep at all?

Information About Your Dream

Question #5.H

In the table below, circle the dreams you have. If something is not listed, please write them down in the empty table space below.

Animals	Robbers	Travelling	Houses	Failure/Exams of exams?
Cats - Dogs	Thieves	Riding	Fruits	Unsuccessful efforts?
Horse	Anxious	Flying	Trees	

Remarks(For Office Use):

Wild animals Snakes	Fearful Ghosts	Swimming Drowning	Water Snow	
Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	
Vomiting Passing stool Urinating Blood-bleeding Excrements / soiling	Romantic Sexual Pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Mosque Church God	
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom ? - For what ?	Death, Whose? Dead bodies Dead persons Part of Body Suicide	
Of people Children Parties Feasts Marriage	Of events Remote Recents Future Prophetic	Physical Exertion Mental Exertion Fatigue Colored Multi-Colored	Business Money Day's work Forgotten work Urge to finish work	

Part 6: About Your Childhood

Remarks(For Office Use):

6.1 The following are some childhood qualities, please place a (+) sign if you had any of the qualities. If they are more intense, add a (++).

	Add (+) here
Mild	
Shy	
Obedient	
Studieus	
Loved Games	
Loved Music	
Hated Music	
Disobedient	
Tamper Tantrum	
Obstinacy	
Aggression/Aggressive	
Hyperactive	
Destructiveness	
Courage	
Possessiveness	
Competition (must win)	
Jealous towards siblings	
Boasting	
Telling lies	

	Add (+) here
Terrified	
Unusual attachments(to whom)	
Habits	
Biting nails	
Picking and playing with: a. mothers body parts b. Shawls, clothes, etc. c. anything else	
Religious	
Dullness of memory	
Slowness (in what)	
Laziness / Indolence	
Sensitive / Emotional	
Unusual fears	

6.2 What was your upbring like? Can you explain? (For example: were you raised in a liberal family? Were you raised in a very strict, conservative family? Were you raised in a city or suburb or village?) Anything you can tell us, helps a great deal.

Remarks(For Office Use):