Montclair Homeopathy, LLC
"a holistic path to health"
Linda Corenthal Robins, MD
92 Church Street
Montclair, NJ 07042
(973) 746-9888

REGISTRATION FORM

Name **Age** **Date of Birth**

Address **City** **State** **Zip**

Please circle which phone you would like us to leave detailed messages regarding your care, should it be necessary:
Phone (Home) **(Cell)**

Email: **Would you like to join our mailing list to receive newsletters about health tips and upcoming workshops? (Y / N)**

Do you have out-of-network benefits: (Y / N)

Referred By **Occupation**

Employment Status: **Work Full Time** **Part Time** **Retired** **Unemployed** **Student** **Homemaker** **Disabled** **How Long?**

Marital Status: **Married** **Divorced** **Separated** **Widowed** **Single** **Never**

Other Physicians/Homeopaths: **Specialty** **Last Seen?**

Living Situation: **Alone** **Parents** **Spouse** **Friend(s)** **Board**

Members of Household:
Name **Age** **Relationship**

_____

_____

_____

_____

Have you ever been hospitalized? **If yes:**
Where **What for** **When**

_____

_____

_____

MEDICAL HISTORY

Print the names of your relatives, living or dead, in the list at the left.

Place an (X) in the appropriate column for any illnesses that you or the relatives listed at the left have had

	Allergies	Anemia	Arthritis/ Gout	Asthma	Bleeding/ Bruising Problems	Cancer or Tumors	Convulsions Epilepsy	Diabetes	Drinking or Drug	Eczema	Emphysema	Heart Trouble	Hepatitis	High Blood Pressure	Frequent Infections
Your Illnesses															
Father															
Mother															
Brother/Sisters:															
Children:															
Grandparents:															

Continued:

	Kidney/ Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problem
Your Illnesses																
Father																
Mother																
Brother/Sisters:																
Children:																
Grandparents:																

Do you use Yes Name & Amount

- Coffee_____
- Cigarettes_____
- Alcohol_____
- Aspirin_____
- Birth Control Pills_____
- Laxatives_____
- Thyroid_____
- Cortisone_____
- Hormones_____
- Medicinal Herbs & Teas_____
- Vitamins_____
- Other drugs_____

Are you allergic to any drugs? (Penicillin, etc)_____

If you have had any of the following tests or immunizations place an (X) in the appropriate box and if you can, give the year you last had them.

Year	Test/Immunization
	❑ Chest x'ray
	❑ Kidney x'ray
	❑ G.I. Series
	❑ Colon x'ray
	❑ Gallbladder x'ray
	❑ EKG
	❑ T.B. test
	❑ Other x'rays
	❑ Small Pox
	❑ Tetanus
	❑ Polio
	❑ Typhoid
	❑ Flu
	❑ Mumps
	❑ Measles
	❑ Other

SYMPTOM QUESTIONNAIRE. Please check or circle the symptoms which apply to you.

- ❑ History of Head Injury
- ❑ Frequent or Severe Headaches
- ❑ Dizzy Spell/ Black out/ Fainting
- ❑ Vision Disturbances
- ❑ Recurrent Styes
- ❑ Hay fever
  - Itching Eyes
  - Sneezing
  - Itching mouth or Ears
  - Difficulty Breathing
- ❑ Other Allergies
- ❑ Chronic Nasal Obstruction
- ❑ Nosebleeds
- ❑ Frequent 'Colds'
  - Just in Head & Nose
  - Sinusitis
  - Goes into Sore Throat
  - Ends up in Chest
- ❑ Asthma
- ❑ Anxious Feeling in Chest
- ❑ Chest Pain
- ❑ Rapid or Skipped Heartbeats
  - Anytime
  - Especially at Night
- ❑ Anxious Feeling in Stomach
- ❑ Digestive Problems
  - Discomfort Right after Eating
  - Discomfort While Eating
  - Discomfort Unrelated to Eating
- ❑ Abdominal Pain, Discomfort, Bloating
  - Above Navel
  - Below Navel
  - Relieved by:
    - Belching
    - Passing Gas
    - Eating
    - Fasting
- ❑ Constipation
  - Long-standing
  - Related to Menses
  - Use Laxatives/Enema's Etc
- ❑ Hemorrhoids/Fissure
- ❑ Wart/Condylomata
- ❑ Diarrhea
  - Loose Stools
  - Frequent Stools
    - Morning, Daytime, Night
    - How Often?____
- ❑ Rectal Pain:
    - Relationship to Stool
    - Before, During, After, Unrelated
- ❑ Back Pain
  - Neck, Mid Back, Low Back
  - Sacro-Iliac
  - Character of Pain:
  - Ache, Sore, Spasm, Cramp
- ❑ Sciatica: Left, Right
- ❑ History of Back Injury
- ❑ Muscular Pains in Arms/Legs
- ❑ Joint Pain or Swelling
- ❑ Restlessness of Hands or Feet
- ❑ Jerking of Limbs
- ❑ Twitching of Muscles
- ❑ Biting Nails
- ❑ Problems with Nails
- ❑ Feet Get Hot
  - Uncover Them at Night
- ❑ Feet Perspire
  - Strong Odor?
- ❑ Sleep Is Very Refreshing
- ❑ Wake Unrefreshed
- ❑ Bad Dreams
- ❑ Sleep Position
  - Sides., Left, Right, Abdomen
  - Back, Knee-Chest
- ❑ Sleep Problems
  - Worries or Anxious Thoughts
  - Hard To Fall Asleep
  - Hard to Stay Asleep
  - Frequent Waking
  - Wake At Specific Time____
  - Wake Early
  - Restlessness
- ❑ Night Sweats
  - Head Neck Chest
  - Back Feet Other

- ❑ Specific Fears or Phobias
  One or two Many

- ❑ Worry A Lot About
  Generalized Anxiety
  State Of The World
  Family/ Children/ Husband
  Business/ Money
  Natural Disasters
  Robbers
  Violence/ Rape
  Speaking in Public
  Health
  Trivial Details
  Other
- ❑ Fastidious/ Perfectionistic
  For Order
  For Cleanliness
  For Being On Time
  In Everything
- ❑ Easily Angered
  Hold It In?
  Let It Out?
    Scream
    Smash/ Throw Things
    Hit People
- ❑ Irritable
  Hold It In?
  With Myself
  With Others
- ❑ Impatient
  If People Are Being Stupid
  If People are Inefficient
  If People Move Too Slowly
  I Hate To Stand In Lines or Drive In Traffic
- ❑ Critical/ Judgmental
  Of Myself, Of Others
- ❑ Ambitious
- ❑ Sadness
- ❑ Jealousy
- ❑ Wish to Die
- ❑ Considered/ Attempted Suicide
  Drugs, Shooting, Drowning, Auto Accident,
  Jumping, Other
- ❑ Weeping
  Easily, Often,
  At the Slightest Thing
  Not in Front Of People
  Not in Years
  Never
- ❑ Masterbation

- ❑ Grief
  Loss Of Loved One
    Of Relationship
    Of Business, Possessions,
    Of Social Position
- ❑ Difficulty Making Decisions
  About Big Things
  About Small Things
- ❑ Forgetful
- ❑ Poor Concentration

WOMEN

- ❑ Frequent Urination
  Night, Day, Both
- ❑ Recurrent Bladder Infection
- ❑ Lose Urine When Cough or Laugh
- ❑ Menopausal Problems
- ❑ Age of Menopause _____
- ❑ Age of First Menses_____
- ❑ Pre-Menstrual Tension
- ❑ Menstrual Irregularities
- ❑ Painful Periods
- ❑ Type of Pain
  Cramping, Stitching, Cutting
  Twisting, Other
- ❑ Clots: Large/Small
- ❑ Endometriosis
- ❑ Fibroid Tumors / Ovarian Cysts
- ❑ Pelvic Infection: Recent, In Past
- ❑ Recurrent Vaginal Infection
- ❑ Sexual Desire
  Low/ Average/ High
  Recent Change?
- ❑ Number of Pregnancies_____
- ❑ Number of Births_____
- ❑ Miscarriages_____
- ❑ Premature Births_____
- ❑ Cesareans_____
- ❑ Abortions_____
- ❑ Genital Warts / Condylomata

MEN

- ❑ Prostate Problems
- ❑ Frequent Urination
  Night, Day, Both
- ❑ Sexual Desire
  Low/ Average/High
  Recent Change?
- ❑ Warts/Condylomata
- ❑ History of Discharge from Penis

GENERAL

- ❑ Complaints Occur Predominantly on One Side Or Part Of The Body: Left, Right, Upper, Lower

- ❑ Time Of Day You Feel The Worst:
  Morning, Mid-Morning, Early Afternoon,
  Late Afternoon, Early Evening,
  Late Evening / Night

- ❑ Time Of Day You Feel The Best:
  Morning, Mid-Morning,
  Early Afternoon,
  Late Afternoon, Early Evening,
  Late Evening / Night

- ❑ Do You Feel: Warmer or Colder Than Most Other People

- ❑ Do You Wear: More Or Less Clothes Than Most Other People

- ❑ Do You Have A Strong Preference For Certain Seasons Or Weather:
  Summer, Winter, Fall, Spring, Hot, Cold, Cold Damp, Humid, Foggy, Overcast, Windy,
  Fresh Air, Thunderstorms

- ❑ Do You Have A Dislike For Certain Seasons Or Weather:
  Summer, Winter, Fall, Spring, Hot, Cold, Cold Damp, Humid, Foggy, Overcast, Windy,
  Fresh Air, Drafts, Thunderstorms

- ❑ How Many Health Practitioners Do You See At This Time_____

- ❑ Current Therapies:
  Regular Medical, Acupuncture, Herbs / Vitamins,
  Chiropractic, Osteopathy, Massage,
  Psychic Healing, Other_____

- ❑ Are There Certain Foods You Crave?

- ❑ Are There Certain Foods You Cannot Stand?

CONSENT FOR TREATMENT: By signing this document, I hereby authorize Dr Corenthal Robins to treat me using homeopathic medicines according to the principles of homeopathic practice. I understand and acknowledge Dr Corenthal Robins will base her treatment decisions on the school of homeopathic practice, and that if I desire to be treated according to the traditional /allopathic school of medicine, I am free to seek such treatment from another physician. In addition, I may be encouraged or required to seek traditional/allopathic treatment by Dr Corenthal Robins. I understand that Dr Corenthal Robins will make the best effort to treat me but makes no guarantees that her homeopathic treatment will cure me.

Signature **Date**