

**Registration Form** (Confidential)

Please download, fill out and email to ingrid@MyHomeopath.ca before your consultation.
I need your **signature** on two of the last pages.

**If you are completing the form for your child,** make sure he/she participates in answering the questions, if old enough. If vaccinated, please bring vaccination card or email copies. Any favourite teddy is welcome.

**Warning:** If you are in the Province of Quebec, please be informed that the Medical College requires that you have received a diagnosis from your doctor before consulting me, as your symptoms may hide a serious illness. At any point during your homeopathic journey, you may consult your doctor. Homeopathy is safe and compatible with any type of treatment.

* **For health tips and invites** sign up to my mailing list (rare emails) at the bottom of my website home page **MyHomeopath.ca** or follow my Facebook, Instagram and Youtube pages **Ingrid Schutt Homeopath**
* **Add my email address to your contacts** to avoid my messages being directed to your spam/junk mail box.

|  |
| --- |
| Name of parents if under 18: |
| **Name and Family name:** |
| Birth year:  | Age: |
| Address: |
| City: | Country: |
| ZIP/Area Code: |
| Cell Phone: |
| Email: |
| Recommended by: |

* \* Try to remember the Year, Month when your first symptoms began.

| **REASONS FOR CONSULTATIONS** |
| --- |
| **Health issue** | **Since when?\* Year?** | **Causes** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

*

| **MEDICATIONS CURRENTLY BEING TAKEN** |
| --- |
| **Medication** | **Since?** | **Side effects**  |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

| **TREATMENTS OR DIETS CURRENTLY BEING FOLLOWED** |
| --- |
| **Treatment or Diet** | **Since?** | **Results** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

| **VACCINES RECEIVED** |
| --- |
| **Vaccines** | **Date** | **Side effects**  |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

* For vaccinated children, please show vaccination card if you have.

| **SURGERIES** |
| --- |
| **Surgeries** | **When?** | **Complications?** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

| **MAJOR INJURIES** |
| --- |
| **Major injuries** | **When?** | **Long term complications** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

**\*\*\*This section is very important.**

* **Write the year and month, if possible,** you would have suffered from the following conditions, call your pharmacist or doctor, if necessary, to trace the exact dates.
* Do not just check with an X, but with the year.

|  | **Year/month** |  | **Year/month** |  | **Year/month** |  | **Year/month** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Abscess |  | Diabetes |  | Leukaemia |  | Sinusitis |  |
| Abortion/miscarriage |  | Emphysema |  | Malaria |  | Skin Disease |  |
| Alcoholism |  | Endométriosis |  | Menopause |  | Syphillis |  |
| Allergies |  | Epilepsy |  | Measles |  | Throat infection/Tonsilitis |  |
| Anemia |  | Flu |  | Mononucleosis |  | Typhoid |  |
| Arthritis |  | Gallbladder stones |  | Mumps |  | Tuberculosis |  |
| Asthma |  | Gonorrhea |  | Otitis |  | Vaginitis/Yeast infection |  |
| Boulimia |  | Gout |  | Parasites |  | Warts |  |
| Bronchitis |  | Hay fever |  | Pleuresy |  | Yellow fever |  |
| Cancer |  | Heart disease |  | Pneumonia |  | Zona |  |
| Chickenpox |  | Hepatitis |  | Prostatitis |  | Others? |  |
| Condylomatas |  | Herpes (genital) |  | Rhumatism/articular |  |  |  |
| Cough/Whooping cough |  | Herpès (fever blister) |  | Rubella |  |  |  |
| Cystitis |  | Infarctus |  | STDs |  |  |  |
| Depression |  | Kidney/Bladder Disease |  | Scarlet fever |  |  |  |

| **ANTIBIOTICS in a prolonged or repetitive way** |
| --- |
| **When?** | **Causes** |
| 1. |  |
| 2. |  |
| 3. |  |

**Have you gained or lost much weight?**

Yes No How many pounds?

| **EXERCISES** |
| --- |
| **Exercises** | **Frequency** |
| 1. |  |
| 2. |  |
| 3. |  |

| **USE** |
| --- |
| **Substances** | **Daily or weekly intake** |
| Tabacco |  |
| Tea |  |
| Coffee |  |
| Alcohol |  |
| Drugs |  |

**How many :**

Pregnancies : Children : Abortions :

**Check the diseases that have affected your relatives**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | X |  | X |  | X |  | X |
| Alcoholism |  | Depression |  | Heart Disease |  | Syphillis |  |
| Allergies |  | Diabetes |  | Skin Disease |  | Mental illness |  |
| Arthritis |  | Epilepsy |  | Paralysis |  | Tuberculosis |  |
| Asthma |  | Gonorrhea |  | Pneumonia |  | Others? |  |
| Cancer |  | Gout |  | Hay Fever |  |  |  |

**Family Health History**

| **Family Member** | **Age if alive** | **Age when passed away** | **Main illnesses** |
| --- | --- | --- | --- |
| Mother |  |  |  |
| Father |  |  |  |
| Sisters |  |  |  |
| Brothers |  |  |  |
| Maternal Grand-mother |  |  |  |
| Maternal Grand-father |  |  |  |
| Paternal Grand-mother |  |  |  |
| Paternal grand-father |  |  |  |
| Uncles and Aunts if major disease |  |  |  |

**When was your last complete medical examination?**

**Are you under the care of a medical doctor?**

**Name of doctor:**

**For what illness?**

| **ILLNESS** | **TREATEMENTS** | **RESULTS** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**Were you ever been treated by a homeopath?**

**Name of Homeopath: (optional)**

| **ILLNESS** | **Homeopathic TREATMENTS** | **RESULTS** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**2nd part of registration form**

**About your symptoms**

**To the best of your knowledge, how did they first appear ? What were the main events in your life BEFORE the first symptoms? (Days, weeks, a month or two) Stress ? Medication? Changes in your life?**

**Please describe what were the symptoms like when they first appeared ? What are they like now?**

**(**What did it feel like or look like ? Sensations ? Pain ? Always same side of body ? Does it come with body cold or heat? Anything else?)

**What makes your symptoms worse or better ?**

**(**What do you do to soothe the pain ? What can trigger the symptoms ? Time, type of food or situations will make it worse ?)

**Have you noticed a singular state of mind the symptoms will put you in ? Mood ? Lassitude ? Anxiety?**

**Other details about your symptoms ? Any changes in your appetite, your food cravings or aversion since ? Are you more sensitive to certain weather since ? Any changes in your sleep since the onset of symptoms?**

Food & Appetite

**What are your INTENSE food cravings ?**

(Healthy or not.)

**What is your very favorite food you can’t do without ?** How intense is your craving ? Every day ?

**Anything you FREQUENTLY want to add to your food ?**

(Hot spices, vinegar, lemon, salt, pepper, sugar, ketchup?)

**Any food AVERSIONS ? Major dislikes, you just could not have.**

**Any food allergies ? You may enjoy the taste but it does not agree with you ?** Digestive reaction, fatigue or else ?

**How is your appetite ? Are you hungry or not hungry at all at specific hours? No breakfast? Hungry at night?**

**Any preference to food temperature ?**

Drinks & Thirst

**How is your thirst ? Day, night ?**

**Any beverage preferences or aversions ? Carbonated?**

**Any temperature preferences or aversions ? Warm, icy cold, room temperature ?**

Digestion

**How is your digestion ?**

**How are your stools and urine ?**

(Stools too frequent or rare, hard or soft, painful transit?)

Climat

**What climate are you sensitive to, if any ? What temperature do you strongly enjoy or dislike ?** (Seasons, thunder, rain, heat, cold, damp?)

Body Temperature

**What is your body temperature like** (Are you very cold, do you suffer from heat, excessive sweating?)

**At what time of day or night?**

**In which part of the body?**

**Since when?**

Menstrual Cycle (current or past)

**Age of first menstruation ?**

**About your cycle ?** Pain, regularity ?

**PMS?** What are you sensitive to during PMS ?

Sleep

**How is your sleep ?**

**How easy is it for you to fall asleep ? Around what time ?**

**Do you feel refreshed in the morning?**

**What do you need to sleep well ?**

(Windows opened even in winter, cold or warmth, covered or uncovered, a fan, noise or complete silence, a specific position ? What is recurring ? Fears ? Thoughts?)

**Any favorite position ?**

**Sleep walking, talking, laughing ?**

**Anything else about your sleep ?**

Dreams

**What are or were the recurring dreams, or the one or two striking dreams you remember?** Do you always remember of forget your dreams ?

**Have you noticed a higher or lower energy cycle during the day?**

Emotions

**What are the movies, books, shows, recurring themes that touch you strongly, to tears, or that you avoid watching?**

**At any time in your life, what movie or scene has moved you to tears?**

| **MOVIES, SHOWS or BOOKS** | **What scene particularly moved me** |
| --- | --- |
| 1.  |  |
| 2. |  |
| 3. |  |
| 4. |  |

**\*\*\* If you can, take the time before the consultation to watch the movies or videos that have affected you one more time to refresh your memory.**

**What are you emotionally sensitive about?** What kind of event can totally upset or change your state of mind in a day? What can make you cry, make you angry, impatient, or any other strong emotion?

**What emotions do you experience frequently?**

(Anger, sorrow, fear, despair, intense joy, worry, humiliation, anxiety…?)

**What have been the most significant events in your life?**

Happy or difficult events. Could you describe them?

**FEARS**

**What scares you, causes great sudden fear ? Any phobias?** Irrational fear even, that is not be related to a life experience ?

**Thank you for taking the time to answer the questions.**

**Please read to the end and sign both the cancellation policy and registration form.

\*\*\* IMPORTANT Read to the end and sign (two signatures required)**

Before the consultation

- **Ladies**: Please mention during the consultation if you are consulting just before or during your period, as the way you take the remedy may vary.

* **Online consultations**, make sure you are
* alone, in a quiet place.
* Have earphones, if possible, to prevent the echo.
* Do not hold cell phone or iPad on your hand. Have device steady and at eye level.

About taking the remedy, what to avoid, etc.

Throughout your homeopathic journey, while taking the remedies, from one consultation to the next, and until your state of equilibrium is well reinforced, it is important to avoid any contact (food, herbal tea, cream, ointment, essential oil, chewing gum, toothpaste...) with à

peppermint,

menthol,

camphor

and eucalyptus

which **can antidote the remedies** and eliminate their effect.

Use a **mint-free toothpaste** throughout the treatment, at least until our next meeting, and possibly for a month or two after your symptoms have completely disappeared.

Try to avoid coffee for at least a week, and two if you can.

THEN NO MINT, no EUCALYPTUS or CAMPHOR. Least coffee possible.

**Natural Health Food stores sell excellent anise or cinnamon toothpaste.**

**If you go to a spa and smell the eucalyptus essential oils,** tell me so you can take another dose in case the healing effect of your remedy stops. These products are strong ANTIDOTES that can totally cancel the healing effect of your remedy, as long as the remedy is still taking its course and as long as your body has not fully and strongly recovered.

**It may be a month or two after your symptoms have fully disappeared.**

**I can not repeat this enough.**

**Avoid alcohol in the first 24 hours and cannabis (CBD and THC) during the treatment.**

—**The goal of the consultation is to determine which remedy is best suited for you,** to balance your vital energy and strengthen your body’s defence mechanism.

**How many granules should I take?**

**If I tell you to buy a 200 K remedy (see my website [HOMEOPATHE.ca](http://HOMEOPATHE.ca) about doses and remedies) make sure the number is 200 and no different.** There are no equivalences. This means 9 CH is not the same as 200 K. But 200K or 200C is the good.

**Should I tell you to take one dose, it is 2 or 3 granules.** The exact number of granules is not as important as how often you will take them.

**It is the contact with the nanoparticles of the remedy that is an electromagnetic message to your body.**

So two or three or 50 granules is the same.

But if I tell you to take it just once, make sure you do not take it any more than indicated. I will tell you if you need to repeat the dose between consultations. So unless I indicate to take another dose, just take the one single dose **and put the tube away.** One single dose does NOT mean one dose a day, unless I precisely tell you so. Should you need more than one dose, I will tell you precisely how often to take the remedy.

**How should I take the remedy?**

Put the granules in the bottle cap and not in your hand. And directly from the cap to your mouth, without allowing the cap to touch your mouth.

New-born, 6 months and under, dilute a dose in about 50 ml of pure water and shake vigorously for about 30 seconds. Each drop or tea spoon you give baby is one dose. Again, it is the single contact of the water with the mouth that is the dose. Not the number of drops. So do not repeat the dose uselessly.

Once the remedy is taken

**Please write down your reactions to the remedy**

Between two consultations, please write down your reactions to the remedy, your dreams, significant events that took place and may have triggered physical or emotional reactions.

The homeopathic treatment is a team work in which you play a central role.

Your answers to my questions and your reactions help me understand the best suited remedy for you.

Balance and healing process

After taking a homeopathic remedy, you may experience what we call a « healing process » in which your body slightly emphasizes the present symptoms or some very old symptoms you’ve had in the past. This process is normal and temporary. It simply shows your body is reacting to the remedy very positively. Just write down your reactions and email me if you have questions.

Additional information

**About healthy nutrition. Back to Basics.**

**Since the age of 15, I have opted for a vegetarian, then vegan, then Plant Based Whole Food diet.**

This diet has proven its ability to maintain a maximum state of health and balance and to prevent or help cure the most common chronic diseases in our society.

I have seen through my years of practice how much this diet has changed the lives of my patients who have adopted it and helped them maintain the balance they gained with homeopathy.

If you are interested in making changes to your diet, I suggest that you watch the following documentaries, which you will surely find online, in order to be well informed and enlightened about the science of nutrition.

**Forks Over Knives**

**The Game Changers**

**Food Choices**

**What The Health**

**Seaspiracy**

**The Montreal Vegetarian Association also offers great support.**

**<https://vegemontreal.org/>**

**On the [NutritionFacts.org](http://NutritionFacts.org) website, you will find a lot of videos and scientific articles on nutrition that are very well explained by Dr. Greger.** Enter any topic you are interested in in the search icon and find the scientific articles published on the subject.

Between consultations, please contact me by email. No texting, no messenger, or any other application. Email me only please.

Do not hesitate to email me again, should you not receive any answer within 24-48 hours.

| **IN BRIEF** | **To check** |
| --- | --- |
| **BEFORE CONSULTATION** | Online consultation | * Be sure to be alone
 |  |
| * Quiet room
 |  |
| * Earphones to prevent echo
 |  |
| **Periods** | **If you are menstruated before or during the consultation, say so** |  |
|  | AVOID herbal tea, cream, ointment, essential oil, chewing gum, toothpaste | **X**  Peppermint |  |
| **X**  Menthol |  |
| **X**  Camphor |  |
| **X**  Eucalyptus |  |
| **X**  Coffee |  |
| **X**  Alcohol (the first 48 hours after taking the remedy) |  |
| **X**  Cannabis (CBD and THC) |  |
| Dose | 2-3 granules = 1 dose |  |
| How? | Put the granules in the bottle cap , and not in your hand |  |
| For babies under 6 months of age:1. Dilute the granules in approximately 50 ml of pure water, spring water
2. Shake vigorously for 30 seconds
3. Give a few drops for one dose.
 |  |
| **ONCE THE REMEDY IS TAKEN** | Please write down in a notebook | Reactions to the remedy (return of old symptoms or others) |  |
| Dreams |  |
| Key events that affect you |  |
| Another dose? | If only one dose indicated, put the tube away  |  |

***CONSULTATION PREREQUISITE***

***The client :***

*1. testifies that he has required the services of the naturopath on his own free will*

*and that he has done so without having been pressured;*

*2. recognizes that he is responsible of using the medical vocabulary that*

*she/he uses and that he cannot impute the responsibility on the naturopath,*

*even if the naturopath uses these terms for explanation purposes;*

*3. is aware that he cannot ask the naturopath to perform any medical act or*

*give a diagnostic reserved to allopathic medicine practitioners, nor that he will incite the therapist to do so;*

*4. acknowledges that the naturopath, did not, at any time, suggest that the client*

*discontinue use of his prescribed allopathic medicine;*

*5. recognizes that he has presented himself under his real name, in good*

*faith and for no other reason than the real one of naturopathic care;*

*6. has given information regarding his private file. Following the adoption*

*of the Personal Information Protection and Electronic Documents Act (PIPEDA), and unless otherwise instructed by yourself, we shall consider that you consent to our keeping in a file, all information you have already given or may give us, orally or in writing. We shall also consider, unless otherwise instructed by yourself by registered mail, that your consent will be valid for a period of five (5) years;*

*7. recognizes that the receipt issued by the therapist is emitted strictly in the*

*intention of acknowledgement of receipt of sums paid for services rendered.*

*The use of this receipt, for any given purpose, including, without limitation, the*

*reimbursement of this amount by anyone, including an insurance company,*

*remains the entire and exclusive responsibility of the client, the therapist not being involved or having any knowledge in any way about the admissibility or the non-admissibility of this receipt for any purpose.*

*The client acknowledges that he has honestly and lawfully introduced himself and for no other purpose than true health care.*

***The client by his signature,*** *testifies to the knowledge and comprehension of*

*the content of the above and accepts to comply to these rules.*

**I have read and understood the general information about consultation and taking remedies and the consultation prerequisite.**

**Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cancellation Policy**

**Should you need to cancel an appointment, you are asked to give a 24 hour notice so that your place can be offered to someone else. Without a 24 hour notice, you will be asked to pay for the consultation.**

**Online consultations should be paid 48 hours in advance. They can be refunded or postponed prior consultation, with a 24 hour notice.**

**\* I have read and understood Ingrid Schutt's appointment cancellation policy.**

**Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for your patience.**

**I look forward to meeting you for the beginning of your homeopathic journey.**

**Ingrid Schutt**