Homeopathy for Better Health

Christie Jergens, BSc Nutrition, CCH, RSHom(NA)
612-501-9265

Client Registration

Name of Client: _____ Birth Date:_____

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Client Address: _____

Home phone: _____ Cell phone: _____

Email address: _____

Emergency Name & Phone: _____

_____

Physician's Name, Address, & Phone: _____

_____

I acknowledge that I am the responsible party for (client) _____, and I understand that payment of homeopathic services is due at time of service.

Signature of Responsible Party: _____ Date: _____

Homeopathic Services Notice

The homeopathic services you have requested are directed at strengthening your constitution and vitality. They are not directed at identifying, treating or preventing specific diseases. Our practitioners are qualified homeopaths but are not licensed physicians. They are prohibited by law from diagnosing or treating disease.
If you have a medical complaint or question about your health it is important that you consult with a physician. Many insurance companies do not pay for homeopathic services and our office will not be sending a claim to your insurance carrier.

CLIENT ACKNOWLEDGEMENT:

It is my personal preference to use the homeopathic services of the homeopaths at Minnesota Center for Homeopathy. I understand that the homeopathic services are NOT MEDICAL treatments and that these homeopaths are not licensed physicians.

Client Signature: _____ **Date:** _____

Parent Signature_____ **Date:** _____
(if client is under age 18):

Client Bill of Rights

(Please sign and return to Christie Jergens)

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4601 Excelsior Blvd Ste 501, St Louis Park, MN 55416
612-501-9265

I am pleased to provide you with this Client Bill of Rights, in accordance with Minnesota laws governing complementary and alternative health care practices.

1. **Degrees, training, and experience.**

   Christie Jergens, BSc Nutrition, CCH, RSHom(NA) practices classical homeopathy at the Minnesota Center for Homeopathy in St Louis Park and in Delano, MN. She graduated from the Northwestern Academy of Homeopathy in 2002. She received a Bachelor's of Science Degree in Nutrition from the University of Minnesota in 2004. She has a postgraduate degree in homeopathy from the Dynamis School for Advanced Homeopathic studies in 2007. She became a Certified Homeopath (CCH) through the Council for Homeopathic Certification in 2013. She is a registered member of the National Society of Homeopaths. In her practice, Homeopathy for Better Health incorporates the gentle healing of homeopathy with nutritional care.

In accordance with Minnesota law, I am providing you with the following notice:

> **The state of Minnesota has not adopted any educational and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for informational purposes only.**

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

2. **Right to file a complaint.** My name and address are listed above. You have a right to file a complaint with me, by writing a letter with details of the nature of the complaint. Also, if you have any concerns, you may file a complaint with the following office:

   Office of Unlicensed Complementary and Alternative Health Care Practice
   Minnesota Department of Health Occupations Program
   85 East 7th Place, Suite 300, PO Box 64882
   St. Paul MN 55164-0882
   651-282-3823, 1-800-657-3957, Fax 651-282-3839

3. **Fees for unit of service**. Fees are payable at the time of service by cash, check, or credit card. (See our Fee Schedule). I do not accept Medicare, Medical Assistance, or General Assistance Medical Care. I do not accept partial payment or waive payment.
4. **Change in services or charges.** You have a right to reasonable notice of changes in services or charges, and we will provide prior notice of any changes.

5. **Description of Services.** Please see the article "What is Homeopathy," provided to you in your clinic information packet.
6. **Information about assessment and recommended service.** You have a right to complete and current information concerning any assessment and recommended service, including the expected duration of the service to be provided. If you have any questions, please ask.
7. **Courteous treatment.** You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
8. **Confidentiality of client information.** Your records and other information about you are confidential. This information will not be released, unless you authorize release in writing, or unless release is required by law.
9. **Access to client records.** You are allowed access to records and other written information, in accordance with Minnesota Statutes, section 144.335.
10. **Other available services.** If you are interested in other available services in the community, you may wish to consult the Minnesota Homeopathic Association.
11. **Change practitioners.** You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
12. **Coordinated transfer.** If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.
13. **Refusing services.** You have the right to refuse services or treatment, unless otherwise provided by law.
14. **No retaliation.** You may assert your rights without retaliation.

I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein and I have had a full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

_____ _____

Witness **Date**

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Fees for Service

$350 Adult Initial Consultation

$285 Child Initial Consultation (Children 12 and under)

$95 Follow up Consultation virtual, phone, or office visit

$35- $60 Brief/ Acute Consultation

$45 After hours or weekend calls

Location, Hours & Scheduling

Christie offers in person, phone or virtual appointments at the Minnesota Center for Homeopathy in St Louis Park or west of the metro in Delano, MN. Hours are by appointment. To schedule a consultation, contact Christie at 612-501-9265 or email christie.jergens@gmail.com

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Health History Form

This information is confidential and will only be released with your signed consent.

Full Name: _____ Today's Date: _____

Address: _____ Birthdate: _____ Age: _____

_____ Best way to contact you: Phone Voicemail E-mail

Phone: (C)_____ (H)_____ E-mail: _____

Sex: _____ Height: _____ Weight (optional.): _____ Occupation: _____

Legal Status: Single Married Divorced Separated Widowed Living Situation: _____

Education (last completed): ☐Elementary ☐HS ☐College ☐Grad school ☐Vocational ☐Prof ☐Post-Grad

Emergency Contact: _____ Relationship: _____ Phone #: _____

If under 18, parents name(s)/address(es): _____

How did you hear of us / referred by? _____

Primary Physician: _____ Other Physicians/Specialists: _____

Other Alternative Health Care Practitioners: _____

The main reason(s) for my visit today are: _____

_____

Family Health History

☐ *Check here if family history is unknown*

	Age	If dead, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check the following items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

Yes		Relationship	Yes		Relationship
☐	Alcohol/drug problem		☐	High blood pressure	
☐	Allergy/asthma		☐	High cholesterol/fat	
☐	Anemia		☐	Kidney disease	
☐	Arteriosclerosis		☐	Liver disease	
☐	Arthritis		☐	Mental illness	
☐	Binge eating/bulimia		☐	Obesity	
☐	Cancer		☐	Skin disease	
☐	Diabetes		☐	Suicide	
☐	Epilepsy/seizures		☐	Syphilis	
☐	Gonorrhea		☐	Thyroid disease	
☐	Heart disease		☐	Tuberculosis	
☐	Other not mentioned		☐	Ulcers	

Past History of Illness and Medical Problems

Surgery: List all surgery	When	Other hospitalizations	When

Broken bones and/or traumatic injuries include all car accidents or concussions	Dates	Major health complaints and duration	Duration

Past History

Yes	When
☐ Acne	
☐ AIDS/HIV	
☐ Alcohol/Drug problem	
☐ Allergies	
☐ Amalgams/silver fillings	
☐ Anemia	
☐ Antibiotics more than once a year	
☐ Anxiety	
☐ Arteriosclerosis	
☐ Arthritis	
☐ Asthma	
☐ Back pain/strain	
☐ Binge eating	
☐ Bladder infection	
☐ Blood clots	
☐ Breast fed	
☐ Breast lump	
☐ Bronchitis	
☐ Bulimia (self-induced vomiting)	
☐ Cancer	
☐ Cataract	
☐ Chemical sensitivity	
☐ Chicken Pox	
☐ Chronic fatigue	
☐ Coccidiomycosis	
☐ Colds, frequent	
☐ Colitis	
☐ Congenital defect	
☐ Counseling	
☐ Depression	
☐ Diabetes	
☐ Ear Infection	
☐ Eczema	
☐ Endometriosis	

Yes	When
☐ Epilepsy	
☐ Epstein Barr	
☐ Fibrocystic Breasts	
☐ Fibroids	
☐ Gallbladder problems	
☐ Glasses/contacts	
☐ Glaucoma	
☐ Gonorrhea	
☐ Gout	
☐ Hay Fever	
☐ Hearing Problem	
☐ Heart attack	
☐ Heart failure	
☐ Heart problem	
☐ Hemorrhoids	
☐ Hepatitis	
☐ Herpes	
☐ Hiatal Hernia	
☐ High blood pressure	
☐ High cholesterol/ triglycerides	
☐ Histoplasmosis	
☐ Hives	
☐ Hypoglycemia	
☐ Infectious Mononucleosis	
☐ Insomnia	
☐ Kidney infection	
☐ Kidney stones	
☐ Kidney problems	
☐ Liver disease	
☐ Measles	
☐ Menstrual problems	
☐ Mental Illness	
☐ Migraine	
☐ Mumps	
☐ Nervous condition	
☐ Neurological problems	

Yes	When
☐ Nightmares—frequent	
☐ Overweight >20lbs	
☐ Pelvic infection	
☐ Peptic ulcer	
☐ Periodontal disease	
☐ Phlebitis	
☐ Pneumonia	
☐ Premenstrual tension	
☐ Prostate problems	
☐ Psychotherapy	
☐ Reactions to vaccinations	
☐ Rheumatic fever	
☐ Root canals	
☐ Scarlet fever	
☐ Sexually transmitted disease	
☐ Sinusitis	
☐ Skin problem	
☐ Sleep disorder	
☐ Stroke	
☐ Suicide attempt	
☐ Syphilis	
☐ Taken steroid (cortisone/prednisone)	
☐ Thyroid problem	
☐ Tonsillitis	
☐ Tooth problems	
☐ Tuberculosis	
☐ Urine problems	
☐ Vaginitis	
☐ Vision problems	
☐ Warts	
Other problems	
☐	
☐	
☐	

Personal History

Current Medications (prescription and non prescription)

Vitamin & Mineral supplements (type & Dosage)

Allergies:
I am allergic to the following medications, foods, chemicals or inhalants:

Lifestyle:
List your favorite foods or cravings:

I do the following for relaxation/recreation/fun/interest:

Activity	Frequency

To control my weight, I have used:
☐fasting: intermittent 1-4 days longer ☐diet pills ☐laxatives
☐self-induced vomiting ☐enemas ☐diuretics ☐health/diet
☐exercise ☐other _____

I am now or have been a smoker: ☐yes ☐no
How many years have you smoked? _____
When did you quit? _____
What do you smoke now? _____
How much? _____

I estimate my use of:
coffee: ___ cups/day decaf: ___cups/day
tea: ___ cups/day soda: ___ cans/day
I use ☐beer ☐wine ☐ "hard" liquor
I consider myself a:
☐non-drinker ☐social drinker ☐heavy drinker ☐alcoholic ☐recovering alcoholic
I use: ☐marijuana ☐other drugs: _____
I have wondered about counseling or medical care for my use of:
☐alcohol ☐tobacco ☐food ☐drugs.

I have participated in an exercise program: ☐yes ☐no
I exercise now on a regular basis: ☐yes ☐no
I think I get enough exercise: ☐yes ☐no
I would like to do more exercise: ☐yes ☐no Note: _____

I find my work:
☐too demanding ☐boring ☐satisfactory ☐very satisfying
My sex life is satisfactory: ☐yes ☐no Libido: (scale 1-10) _____

I am sometimes fearful of:	
☐ being alone	☐ darkness
☐ robbers	☐ sudden noises
☐ high places	☐ the unknown
☐ animals/bugs (specify):	☐ other (fire, accidents, etc):
I worry about:	☐ job /work
☐ money / security	☐ family / family life
☐ relationships	☐ other:

I sleep well: ☐yes ☐no Describe: _____

I currently see a psychotherapist or other mental health professional:
☐yes ☐no
I have had a therapeutic massage: ☐yes ☐no
I currently see a chiropractor, osteopath, rolfer, massage therapist or other body work professional. ☐yes ☐no Note: _____
I have been arrested: ☐yes ☐no Note:_____
I have been in the military ☐yes ☐no
I have been a victim of abuse: ☐physical ☐emotional ☐sexual
Notes: _____

My spiritual life is satisfactory: ☐yes ☐no
I am currently involved in a regular spiritual program ☐yes ☐no

My last physical exam was _____

Life Changes

In the last 12 months, what changes have occurred in your life?

Personal Life

Family Life

Social Life

Work Life

Sex Life

Any other significant changes

How do you feel when you wake up in the morning?

How often do you ordinarily eat (snacking included) during a 24 hour period?

Please add anything that you would like to tell us that has not already been covered.

Review of Systems

Answer "yes" if you have had these symptoms **in the past 12 months**

Yes

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food cravings
- ☐ Frequent infections
- ☐ Night Sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Unusual hair loss/growth
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problems
- ☐ Head injury
- ☐ Seizure/convulsions
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under the eyes
- ☐ Date last eye exam
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breathing
- ☐ Chronic cough
- ☐ Bloody/yellow sputum

Yes

- ☐ Shortness of breath
- ☐ with exertion
- ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Chest pain or pressure
- ☐ at rest
- ☐ with exertion
- ☐ with stress
- ☐ with eating
- ☐ down left arm, neck or back
- ☐ accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skipped heartbeats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficulty swallowing
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning during urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Loss of control/urine
- ☐ Foul odor to urine

Yes

- ☐ Low back pain
- ☐ Muscle pain
  Where:
- ☐ Muscle weakness
  Where:
- ☐ Joint pain
  Where:
- ☐ Joint pain aggravated by motion
- ☐ Joint pain relieved by motion
- ☐ Swollen joints
- ☐ Stiff joints

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt urine stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

WOMEN

Last menstrual period
Age began menstruation
Age at menopause
# of pregnancies
# of live births
# of abortions/miscarriages
Usual length of cycle days
Usual length of period days
Date of last Pap smear

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility
- ☐ Breast fed a baby

Other: