

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)

Homeopathy for Better Health
Christie Jergens, BSc Nutrition, CCH, RSHom(NA)
Delano or Edina Locations
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 Edina 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

Homeopathy for Better Health

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

Fees for Service

\$400 Adult Initial Consultation (2 hour appointment)

\$325 Child Initial Consultation (Children 12 and under) (1-1.5 hour appointment)

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

\$45- \$75 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 Edina or west of the metro in Delano, MN. To schedule a consultation, contact Christie at 612-501-9265 or email christie.jergens@gmail.com

Homeopathy for Better Health
 Christie Jergens, BSc Nutrition, CCH, RSHom(NA)
 612-501-9265

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 |
|--------------------------|----------------------------|
| <input type="checkbox"/> | Alcohol/drug problem _____ |
| <input type="checkbox"/> | Allergy/asthma _____ |
| <input type="checkbox"/> | Anemia _____ |
| <input type="checkbox"/> | Arteriosclerosis _____ |
| <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | Binge eating/bulimia _____ |
| <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | Epilepsy/seizures _____ |
| <input type="checkbox"/> | Gonorrhea _____ |
| <input type="checkbox"/> | Heart disease _____ |
| <input type="checkbox"/> | Other not mentioned _____ |

- | Yes | Relationship |
|--------------------------|----------------------------|
| <input type="checkbox"/> | High blood pressure _____ |
| <input type="checkbox"/> | High cholesterol/fat _____ |
| <input type="checkbox"/> | Kidney disease _____ |
| <input type="checkbox"/> | Liver disease _____ |
| <input type="checkbox"/> | Mental illness _____ |
| <input type="checkbox"/> | Obesity _____ |
| <input type="checkbox"/> | Skin disease _____ |
| <input type="checkbox"/> | Suicide _____ |
| <input type="checkbox"/> | Syphilis _____ |
| <input type="checkbox"/> | Thyroid disease _____ |
| <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | 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	Yes	When	Yes	When
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Nightmares—frequent	_____
<input type="checkbox"/> AIDS/HIV	_____	<input type="checkbox"/> Epstein Barr	_____	<input type="checkbox"/> Overweight >20lbs	_____
<input type="checkbox"/> Alcohol/Drug problem	_____	<input type="checkbox"/> Fibrocystic Breasts	_____	<input type="checkbox"/> Pelvic infection	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Peptic ulcer	_____
<input type="checkbox"/> Amalgams/silver fillings	_____	<input type="checkbox"/> Gallbladder problems	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Glasses/contacts	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Prostate problems	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Hay Fever	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Hearing Problem	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Root canals	_____
<input type="checkbox"/> Bladder infection	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Breast fed	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Skin problem	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Bulimia (self-induced vomiting)	_____	<input type="checkbox"/> High cholesterol/triglycerides	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Histoplasmosis	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Infectious Mononucleosis	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Coccidiomycosis	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Kidney problems	_____	<input type="checkbox"/> Urine problems	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Vision problems	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Menstrual problems	_____	<input type="checkbox"/> Warts	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mental Illness	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Ear Infection	_____	<input type="checkbox"/> Migraine	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Nervous condition	_____	<input type="checkbox"/>	_____
		<input type="checkbox"/> Neurological 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
<hr/>	<hr/>

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, rolfar, 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: