Stewart Homeopathy
Teresa Stewart CCH, C.HP
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612-720-2332

Client Bill of Rights

We are 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.

   Teresa Stewart is *a Council Certified Homeopath (CCH) and a* graduate of a 4 ½ year homeopathic training program with Northwestern Academy of Homeopathy (NAH), in the Twin Cities. She considers her education ongoing as she actively pursues continuing education. She is also enrolled in a Health couching program as a Functional Nutritionist. .

   Teresa has a background in finance, working in corporate America from many years while pursuing her passion for health and healing. She fell in love with homeopathy in 1993, while raising her family in Australia. She works with families locally and remotely.

   The current care you receive will be of a homeopathic nature and **not** allopathic (conventional medicine). Clients are advised to have and receive allopathic care from their primary care physician or provider. We will be pleased to coordinate your health care with your primary physician according to your wishes.

   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 INFORMATION 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. Our names and address are listed above. You have a right to file a complaint with us, 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). We do not accept Medicare, Medical Assistance, or General Assistance Medical Care. We do not accept partial payment or waive payment. (See our Payment Policy).

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, and available in our reception room.
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

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

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

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 participated in an exercise program: ☐ yes ☐ no
I exercise now on a regular basis: ☐ yes ☐ no

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 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 _____

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
- ☐ 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
- ☐ 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:

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

Lifestyle Comments

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

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Client Registration

Name of Client: _____ Birth Date:_____

Relationship to Responsible Part: ☐ 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 (if client is under age 18):_____ Date: _____