Date Form Completed 17/12/2024

HOMEOPATHIC TREATMENT INFORMATION FORM

Name Isadora Mendes

Date of Birth 27/10/1973 Place of Birth Maputo, Mozambique

Time of Birth 3:45 am Cultural Heritage Portuguese

Blood Type A +

Postal Address 9 Brissendon Street, Maudsland

City Gold Coast State QLD Post Code 410

Residential Address (if different from postal) As above

Mobile Phone 0450909902 E-mail isadoram73@icloud.com

Occupation Learning & Development Advisor Work Environment Office

How did you hear about Return to Health? Niece and sister-in-law

General Medical Practitioner Dr Sue Raju

Address Shop 8/1 Pitcairn Way, Pacific Pines QLD 4211 Telephone (07) 5596 8400

Other Practitioners regularly consulted Dr Paul Fisser

Consent: I confirm that I have voluntarily requested Homeopathic treatment & that the information in this form is correct and complete to the best of my knowledge. Signature of Client (or Parent/Legal Guardian if underage)

Isadora Mendes Date 17/12/2024

Purpose of Treatment. Please write what you would most like help with:

Thyroid, weight, hormones, brain fog, sleeplessness, where do I start!

Are you / Do you: (Please select and detail):

– Pregnant Yes ☐ No ☑ If yes, how many weeks? _____

– Smoke Yes ☐ No ☑ If yes, how many on average per week? _____

– Regularly drink alcohol Yes ☑ No ☐ If yes, how many on average per week? 1

– Take recreational drugs Yes ☐ No ☑ Please detail _____

– Have any grafts, implants or prosthetics Please detail N/A

All treatments and drugs currently used, including alternative treatments & supplements:

Drug or Treatment	Dosage	Reason	Any Problems
Oroxene	100 mg	thyroid	
Prunlax	4 tablets	consiptation	
Zinc	1 capsule		
Nattokinase and Bromelain	1 capsule each		
Curcumin	1 capsule		

Any current illnesses or complaints and their treatments:

Illness or Complaint	Duration	Treatment Given
Hashimotos		oroxene
Weight gain		
Menopause		

Please fill in as much as you can. It will be useful in finding the best way of assisting you achieve wellness.

Childhood Illnesses:

Nature of Illness	Age	Duration	Anything Unusual	Treatment
Scarlett fever	toddler	Unknown	Unknown	Unknown
Fever convulsions	toddler	unknown	high fevers	tonsillectomy

Adult Illnesses, Accidents or Operations:

Illness /Accident/Operation	Age	Treatment
Hashimotos	41	Oroxine 100 mg
Tubes tied and endometreosis	35	Surgery
HPV	25	Laser surgery

Vaccination and Immunisation History:
Please complete in full or supply a copy of your vaccination record. Please note down ALL symptoms experienced after each vaccine or immunisation.

Vaccination/Immunisation	Age	Any Complications or After Effects
Covid	49	usual flu symtoms
Standard childhood vaccines	0 - 4	none

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Family Health History:
Please detail any serious illnesses in your blood family as well as any causes of death.

Relative + Illness / Condition	Cause of Death if relevant
Covid - Mom	Covid

Major Life Events:
E.g. death of a relative, marriage, divorce, birth of children, immigration, major career changes, accidents, injuries, trauma, etc:

Event	Age	Duration	Anything Unusual	Treatment received
Immigration	33	2 years	Stressed, anxiety	None
Husband had affair	43	1 week	Trauma, stressful	Took a mild antidepressant
Death of 4 family members	48	1 month	Highly stressful, trauma	Took a mild antidepressant
Death of cousin from cancer	50	18 months	Stressful, trauma	

HAIR & BLOOD SAMPLE CONSENT

Hair and blood samples may be helpful additional sources of information. All samples are stored securely with the client file and only accessed by the prescribing homeopath for the purpose of treatment. If you are willing to supply a hair and blood sample, please indicate so here. Your prescribing homeopath will discuss the details with you.

I am willing to provide a hair and blood sample for the purposes of homeopathic treatment.

Signature of Client Isadora Mendes Date 17/12/2024

VIDEO AND PHOTOGRAPHY CONSENT

Video and photographic copies of symptoms or behaviours may be helpful additional sources of information. All files are stored securely with the client file and only accessed by the prescribing homeopath for the purpose of treatment. If you are willing to supply relevant video and photo material, please indicate so here. Your prescribing homeopath will discuss the details with you.

I (full name) _____, of (address), _____

_____

hereby consent to video or images to be taken of (client name(s)) _____

_____

The collected media is to be used by Return to Health only, for the purposes of a visual record of progress and assisting with treatment planning.

Signature _____ Date 17/12/2024

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TREATMENT AGREEMENT

I Isadora Correa Mendes, wish to undertake Homeopathic treatment with Return to Health, and do so voluntarily. Treatment will cover the following members of my family: myself (if applying on behalf on a minor).

1. I agree to the following terms and acknowledge that Return to Health retains the right not to treat beyond the initial consult or to discontinue treatment at any time:
2. I will discuss any concerns regarding my treatment or health matters with my Homeopath via email or telephone.
3. I will not ask social media users for specific Homeopathic advice, nor shall I offer such advice. It is understood that it is up to my qualified Homeopath to address such calls for specific assistance.
4. Whilst under the care of a Return to Health Homeopath I will not approach another Homeopath for advice or prescriptions.
5. If I participate in social media discussions about Homeopathy, I agree not to join pseudo-homeopathic pages seeking advice or self-prescribing. These pages are not affiliated to nor endorsed by Return to Health.
6. I confirm that I will declare all allopathic drugs and natural medicines and supplements to my Homeopath.
7. I confirm that any prescription medication I am taking while under the care of a physician will not be withdrawn without their supervision.
8. I understand that my Homeopath is not a medical doctor and suggestions should not be taken as a diagnosis or direction against a licensed physical or mental care professional.
9. I understand that I am seeking alternative and complementary treatment in the form of homeopathy and that decisions regarding orthodox medical advice or treatment are mine alone.
10. I have read the above and agree to all terms.

Print Name Isadora Correa Mendes

Signature Isadora Mendes Date 17/12/2024

TREATMENT & PAYMENT TERMS

Please read the Fees and Payment Terms document provided in detail, and indicate your agreement to the terms by completing the section below.

Agreement to Terms: I (full name) Isadora Correa Mendes, hereby agree to the treatment and fee terms set out above.

Signature Isadora Mendes Date 17/12/2024