Homeopathic Intake Form

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Homeopathic consultation is facilitated when there is a complete picture of the individual's mental, emotional and physical states of health. This includes symptoms that affect both physical sensations (what does it feel like), and function (how it impacts you) and what ameliorates or aggravates each symptom.

Date: _____
Name _____ Age___ Birth date _____Sex ___
Address_____
City_____ State _____ Zip _____
Phone (home)_____(work)_____ (cell)_____
E-mail _____
Occupation _____Full-time/Part-time _____Retired____
Employed by_____
Education_____
Married ____ Separated _____ Divorced_____ Widowed _____ Single_____

Are you familiar with or have you ever had Homeopathic treatment? _____.
If yes, what remedies have you taken and what remedies have helped?
_____
_____.

In your opinion, what are your most important health problems? List as many as you can in order of importance:
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Past Medical History:
When did your complaint or ailment begin?

What do you think causes or has caused your ailment or complaint?
_____
_____

Have you had an experience (traumatic, illness, vaccine or other) that did or still affects you deeply? Explain.
_____
_____

The general state of my health has been:
Excellent____ Good ____Fair ____ Poor ____

What childhood illnesses have you had?

____ Rubella (3 day-measles) ____ Mumps ____ Chickenpox
____ Measles (2 weeks) ____ Whooping Cough ____ Asthma
____ Scarlet Fever ____ Rheumatic Fever
Others: _____

If you have had any of the following tests or immunizations, place an (X) on the appropriate line and/or give the (approximate) year.

Year	Tests	Year	Immunizations
_____	Chest x-ray	_____	Smallpox
_____	G.I. Series	_____	Tetanus
_____	Colon x-ray (Barium enema)	_____	Polio
_____	Kidney x-ray	_____	Typhoid
_____	Electrocardiogram	_____	Diphtheria
_____	MMR	_____	Flu
_____	Other _____		

Your Health History:

Now	Past	Never		Now	Past	Never	
____	____	____	Addictions	____	____	____	Diabetes
____	____	____	Alcohol	____	____	____	Drugs
____	____	____	AIDS	____	____	____	Eczema
____	____	____	Allergies	____	____	____	Emphysema
____	____	____	Anemia	____	____	____	Epilepsy
____	____	____	Anorexia	____	____	____	Gout
____	____	____	Asthma	____	____	____	Heart Condition
____	____	____	Bleeding	____	____	____	Hepatitis
____	____	____	Bruising	____	____	____	Herpes
____	____	____	Bulimia	____	____	____	Hypertension
____	____	____	Cancer	____	____	____	Kidney Disease
____	____	____	Colitis	____	____	____	Liver Disease
____	____	____	Convulsions	____	____	____	Mental Disease
____	____	____	Depression	____	____	____	Migraines
____	____	____	Obesity	____	____	____	Pneumonia
____	____	____	Rheumatism	____	____	____	STD
____	____	____	Thyroid	____	____	____	Tuberculosis

Hospitalizations: List as best as you can.

Type of illness/operation	Date:	Where:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Use:

Yes		Amount	Yes		Amount
____	Coffee	_____	_____	Birth Control Pills	_____
____	Cigarettes	_____	_____	Sedatives/Tranquilizers	_____
____	Alcohol	_____	_____	Thyroid	_____
____	Aspirin	_____	_____	Laxatives	_____
____	Other Drugs	_____	_____	Cortisone	_____

Yes	Amount	Yes	Amount
____ Electric Blanket	_____	_____ Hormones	_____
____ Herbs/Teas	_____	_____ Vitamins	_____
____ Recreational drugs	_____	_____ Other therapies	_____

Are you allergic to any drugs (penicillin, etc.) Are you allergic to foods or other substances?_____

What happens when you have an "allergy attack" or "sensitivity reaction"?

_____

Family History:

Please list ages, and if deceased, what was the cause and at what age:

Relation	**Living**	**Died**	**Cause**	**Age**
Your mother	_____	_____	_____	_____
Your father	_____	_____	_____	_____
Your brother (s)	_____	_____	_____	_____
	_____	_____	_____	_____
Your sister (s)	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's side				
Your grandfather	_____	_____	_____	_____
Your grandmother	_____	_____	_____	_____
Father's Side				
Your grandfather	_____	_____	_____	_____
Your grandmother	_____	_____	_____	_____

Has any **blood relative** had any of the following?

Yes	No	D.K. (Don't Know)	Yes	No	D.K.
___	___	___ Allergies	___	___	___ Gout
___	___	___ Anemia	___	___	___ Hay Fever
___	___	___ Arthritis	___	___	___ Heart Attack
___	___	___ Asthma	___	___	___ High Blood Pressure
___	___	___ Bleeding	___	___	___ Seizure/Epilepsy
___	___	___ Cancer	___	___	___ Sickle Cell Anemia
___	___	___ Diabetes	___	___	___ Stroke
___	___	___ Depression	___	___	___ Thyroid Trouble
___	___	___ Eczema	___	___	___ Tuberculosis
___	___	___ Glaucoma	___	___	___Venereal Disease

Symptoms: Please mark **1** (mild), **2** (moderate), **3** (severe) if any of the following apply to you NOW or in the PAST.

Skin

Now	**Past**	
____	____	skin: rough, dry, scaly, bumpy, itchy (circle)
____	____	rashes, warts, moles, cysts (circle)
____	____	light or dark patches of skin (circle)
____	____	increased hair growth in unusual places
____	____	pimples

Now Past

____ ____ color changes in nails
____ ____ hives
____ ____ loss of hair
____ ____ ridges, pits or spots on nails
____ ____ infections, fungal symptoms

Blood, Lymph, Immune

____ ____ Swollen or painful lymph nodes
____ ____ Wounds heal slowly
____ ____ Difficulty stopping bleeding
____ ____ Swollen glands
____ ____ Bruise easily

Endocrine

____ ____ Excessive hair growth
____ ____ Cold hands or feet
____ ____ Weakness
____ ____ Can't stand cold
____ ____ Chronic fatigue
____ ____ Prefer cold weather
____ ____ Unexplained thirst
____ ____ Increased hunger
____ ____ Can't stand heat
____ ____ Profuse sweating

Head

____ ____ Dizziness
____ ____ Severe headaches
____ ____ Seizures/tics/spasms
____ ____ Double vision
____ ____ Fainting spells
____ ____ Injuries

Eyes

____ ____ Infections
____ ____ Blurred vision
____ ____ Sensitive to light
____ ____ Near/far sighted
____ ____ Floaters
____ ____ Injuries

Ears

____ ____ Discharge from ears
____ ____ Pain in ears
____ ____ Hearing trouble
____ ____ Infections
____ ____ Injuries
____ ____ Noises in ears

Nose

____ ____ Nose bleeds
____ ____ Sinus problems
____ ____ Injury
____ ____ Loss of smell
____ ____ Obstruction - difficulty breathing through nose

Mouth

____ ____ Sore mouth or tongue
____ ____ Infections
____ ____ Loss of teeth
____ ____ Bad breath
____ ____ Gum disease
____ ____ Speech difficulties

Throat

____ ____ Persistent hoarseness
____ ____ Difficulty swallowing
____ ____ Loss of voice
____ ____ Pain
____ ____ Infections
____ ____ Swelling

Neck

____ ____ Stiffness
____ ____ Injuries
____ ____ Swelling

Respiratory

Now Past

____ ____ Unexplained fever ____ ____ Night sweats
____ ____ Chest pain ____ ____ Shortness of breath
____ ____ Wheezing ____ ____ Daily cough
____ ____ Infections ____ ____ Difficulty breathing
____ ____ Difficulty breathing at night (wakes you up)

Cardiovascular

____ ____ Chest pain when walking ____ ____Varicose veins
____ ____ Ankle-swelling ____ ____ Hypertension (HBP)
____ ____ Shortness of breath ____ ____ Leg pain (walking)
____ ____ Heart palpitations (fluttering, pressure, skipping, rapid beat)

Digestive System

____ ____ Frequent or severe symptoms ____ ____ Vomiting, nausea
____ ____ Blood in stools ____ ____ Hemorrhoids
____ ____ Change in bowel movements ____ ____ Black stools
____ ____ Heartburn ____ ____ Vomiting blood
____ ____ Indigestion ____ ____ Anal itching
____ ____ Excessive belching ____ ____ Yellow jaundice
____ ____ Stomach pain ____ ____ Diff. swallowing
____ ____ Distress from fats or greasy foods
____ ____ Stools yellow, clay-colored, foul odored, has undigested food
____ ____ Bad breath, bad taste in mouth; body odor (including feet)
____ ____ Indigestion after meals (fullness, bloating, sourness, etc.)
____ ____ Heavy, full feeling after eating
____ ____ History of constipation or diarrhea
____ ____ Excessive lower bowel gas
____ ____ Stomach pain occurs 5 or 6 hours after eating
____ ____ Indigestion occurs immediately after eating
____ ____ Nervousness, shaky feelings, headaches, relieved by eating
____ ____ Irritable if late for meal, miss meal, or before eating breakfast
____ ____ Sudden, strong craving for sweets or alcohol
____ ____ Wake up at night feeling hungry
____ ____ Overweight ____ ____ Loss of appetite
____ ____ Sudden weight loss ____ ____ Sudden weight gain
____ ____ Infection ____ ____ Injury
____ ____ Sleepy during the day? When? _____

How often do you have bowel movements?_____

Do you strain at stool? _____. Have you had a change of appetite? _____Increase / decrease? _____.Of what does your diet consist ? _____

_____

_____

Do you snack?_____. On what? _____

_____What foods, condiments, or any other substances (i.e. chocolate, ice-cream, mustard, sour, spicy, etc.) do you crave? _____

Are you repelled by, or do you dislike any foods?

_____

Are there any foods that trouble or aggravate or do not agree with you? In what way?

_____

Are you thirsty? ____ For hot drinks _____ For cold drinks_____
Ice in your drinks ____ Do you like to chew ice? ____

Urogenital System

Now Past

____ ____ Frequent urination ____ ____ Painful urination
____ ____ Night urination
____ ____ Trouble starting urine ____ ____ Trouble holding
____ ____ Frequent urging with scant urination

Male Problems

____ ____ Any prostate problems
____ ____ Discharge from penis
____ ____ Difficulty achieving or maintaining an erection
____ ____ Painful erection
____ ____ Difficulty with ejaculation
____ ____ Lumps, swelling or pain in testicles
____ ____ Infection
____ ____ Infertility
____ ____ Injury

Female Problems

____ ____ Discharge from vagina
____ ____ Difficulty feeling sexually aroused
____ ____ No lubrication when aroused
____ ____ Never or seldom have orgasms
____ ____ Sex is painful ____ ____ Pelvic pain
____ ____ Menstrual flow is excessive/absent (circle)
____ ____ Bleeding or spotting between periods
____ ____ Pain before, during/after periods (circle)
____ ____ Infection ____ ____ Infertility
____ ____ Lumps in breast
____ ____ Premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, (circle) other…

Spine and Extremities

____ ____ Joint pain, swelling, stiffness, tingling, numbness
Where? _____
____ ____ Muscle cramps ____ ____ Backaches
____ ____ Burning soles of feet
____ ____ Unusual redness of palms of hands
____ ____ Injuries
____ ____ Other
Have you ever had arthritis? _____
Where _____What kind _____

Nervous System

Now	Past		Now	Past	
____	____	Loss of balance	____	____	Paralysis
____	____	Lack of strength (seizures, stiffness)			
____	____	Convulsions	____	____	Numbness
____	____	Tremor (shaking, involuntary movements, tics, spasms)			

General

Are you a warm or chilly person? _____

Are you sensitive to changes in weather? _____ sun _____ drafts _____ wind ___ noise ___ ordered environment _____ other _____

_____

When in bed, if you feel warm, what part of your body would you tend to uncover first? _____. Do you usually dream? _____. Are there specific dreams or recurring themes to your dreams? If so, what?_____

_____

Mental/Emotional

Now	Past		Now	Past	
____	____	Restlessness	____	____	Anxiety
____	____	Excessive worry	____	____	Nervousness
____	____	Memory trouble	____	____	Trouble concentrating
____	____	Depression	____	____	Crying spells
____	____	Trouble sleeping	____	____	Frequent nightmares
____	____	Trouble getting along with people			
____	____	Easily angered	____	____	Feelings of worthlessness
____	____	Mood swings	____	____	Suicidal thoughts
____	____	Fearful	____	____	Excess stress
____	____	Loss of someone dear through death or separation			
____	____	Always put others' interests before mine			
____	____	See things that others don't			
____	____	Hear voices			
____	____	Think others want to hurt you			
____	____	Don't know how to relieve stress			
____	____	Is order important to your surroundings?			
____	____	Are you generally late for appointments?			
____	____	Do you tend to leave things undone until the last minute			
____	____	Peculiar sensations? What? _____			

Where?_____

How do symptoms of stress show up in you (physically/emotionally)?

_____

_____

What are your triggers for stress_____

_____

_____

How do you alleviate stress?_____

_____

_____

****

General Questions:
6. Is there a specific kind of weather/season that bothers you?

_____
7. How does a change of weather affect you?

_____
8. How do you feel in bright sunlight?

_____
9. Do you have any special reactions before or during a storm?

_____
10. How do you react to drafts of air (e.g., an open window, a fan on you)?

Do you like to sleep with the window open even when it is cold out?

_____
11. How do you react to sudden changes in temperature, e.g., going out into cold air, into a hot room, etc.? _____
Would you characterize yourself as a "chilly" or "hot" person? For instance, does it take a long time for you to warm up in bed or do you prefer to throw the covers off?; do like/dislike being next to a heater or stove?, etc.

_____
12. Do you like/dislike sitting, standing, lying, walking in open air?

_____
13. Do you perspire a great deal? If so, when and where on your body?

_____
14. Is there a time of day that tends to be a down time for you?

_____

Mental/Emotional:
15. What worries you?_____

_____
16. Do you cry easily? In what situations?_____

_____
17. When upset, do you tend to tell other people or keep it to yourself?

_____
18. When and on what occasions to you feel frightened or anxious?

_____
19. What are the greatest griefs that you have experienced in your life?

_____

20. What are your greatest joys?

_____

21. What makes you sad, makes you feel the blues?

_____

22. What bothers you most in other people? How, if at all, do you express it?

_____

23. Do you have a lack of self-confidence, a sense of low-esteem?

_____

24. Do you have recurring dreams? Do they have a central theme?

_____

25. What would you need to make you happy?

_____

26. Ideally, what would you like to do for work? Is your work fulfilling?

_____

27. If you won the lottery, what would you do?

_____

28. How do other people view you?

_____

29. Is there anything that you would like to change about yourself?

_____

Food:

30. How do you feel before, during and after meals?_____

_____

31. Are there specific foods that you crave?_____

_____

32. Are there foods that you would not eat under any circumstances?

_____

33. How much do you drink in a day? How thirsty do you tend to get?

_____

Sleep:

34. How is your sleep? Do you tend to wake up at a particular time? If so, why?

_____

35. How do you feel in the morning?_____

_____

Women:

36. Number of pregnancies, of children, of miscarriages, of abortions?

_____

37. At what age did your menses begin?_____

38. Are they (were they) irregular, early, late, etc.?_____

_____

39. How do you (did you) feel before, during and after your period?

_____

Is there anything else you wish to add?

_____

_____

_____