Why Suffer? Get Healthy! Get Homeopathy!!

Name: _____ Birth date: _____
Address: _____ Phone: _____
City: _____ Postal Code: _____ Work Phone: _____
Email: _____ Cell Phone: _____
Sex: ◊ M ◊ F Weight: _____ Height: _____
School: _____ Grade: _____ GPA: _____
Lives with: _____ Number of Siblings: _____
Referred by: _____
Emergency Contact: _____ Phone: _____

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies); include type of illness, month and year hospitalized, name of hospital, city and state

#1: _____
#2: _____
#3: _____

Allergies: _____
Medications (Type, Dosage, Frequency): _____

_____

Medicinal Herbs, Vitamins, Teas: _____

_____

Do you use: ◊ Coffee: Amount _____ ◊ Cigarettes: Amount _____
◊ Alcohol: Amount _____ ◊ Other drugs: Amount _____

Tests	Year	Immunizations	Year
Chest x-ray		Smallpox	
Electrocardiogram		Tetanus	
TB test		Polio	
GI series		Typhoid	
Kidney x-ray		Mumps, Measles	
Barium Enema		Flu	
Other x-rays		Other	

If you have been bothered recently by any of these problems check yes:

Y	N		Y	N		Y	N	
◊	◊	frequent/severe headaches	◊	◊	recurring indigestion	◊	◊	worry a lot
◊	◊	back pains	◊	◊	frequent belching	◊	◊	scary dreams/thoughts
◊	◊	neck lumps or swelling	◊	◊	nausea	◊	◊	feeling of desperation
◊	◊	loss of balance	◊	◊	vomiting	◊	◊	shy or sensitive
◊	◊	dizzy spells	◊	◊	pain in abdomen	◊	◊	dislike criticism
◊	◊	blackouts/fainting	◊	◊	bloated abdomen	◊	◊	angered easily
◊	◊	wear glasses	◊	◊	constipation	◊	◊	annoyed by little things
◊	◊	blurry vision	◊	◊	loose bowels	◊	◊	family problems
◊	◊	eyesight worsening	◊	◊	black stools	◊	◊	problems at work
◊	◊	see double	◊	◊	grey or whitish stools	◊	◊	sexual difficulties
◊	◊	see halos or lights	◊	◊	pain in rectum	◊	◊	change of sexual energy
◊	◊	eye pains or itching	◊	◊	itching rectum	◊	◊	considered suicide
◊	◊	watering eyes	◊	◊	blood with stools	◊	◊	loss or gain in weight
◊	◊	earaches	◊	◊	frequent urination	◊	◊	loss of appetite
◊	◊	hearing difficulties	◊	◊	involuntary urination	◊	◊	always hungry
◊	◊	running ears	◊	◊	burning on urination	◊	◊	fatigue or weariness
◊	◊	noises in ears	◊	◊	black or bloody urine	◊	◊	fever or chills
◊	◊	dental problems	◊	◊	weak urine stream	◊	◊	motion sickness
◊	◊	sore or bleeding gums	◊	◊	difficulty starting urine	◊	◊	night sweats
◊	◊	sore tongue	◊	◊	constant urge to urinate	◊	◊	hot flashes
◊	◊	congested nose	◊	◊	aching muscles or joints	◊	◊	warm or cold than others
◊	◊	running nose	◊	◊	swollen joints			<u>BOYS ONLY</u>
◊	◊	sneezing spells	◊	◊	back or shoulder pains	◊	◊	burning or discharge
◊	◊	head colds	◊	◊	weakness in arms/legs	◊	◊	swelling on testicles
◊	◊	nose bleeds	◊	◊	painful feet	◊	◊	painful testicles
◊	◊	sore throat	◊	◊	trembling			<u>GIRLS ONLY</u>
◊	◊	difficulty swallowing	◊	◊	numbness	◊	◊	missed period
◊	◊	hoarse voice	◊	◊	leg cramps	◊	◊	menstrual problems
◊	◊	wheezing or gasping	◊	◊	skin trouble	◊	◊	bleeding btwn periods
◊	◊	frequent coughing	◊	◊	scalp problems	◊	◊	heavy bleeding
◊	◊	cough up phlegm	◊	◊	itching or burning skin	◊	◊	bearing down feeling
◊	◊	cough up blood	◊	◊	bruise easily	◊	◊	vaginal discharge
◊	◊	chest colds	◊	◊	nervousness or anxiety	◊	◊	genital irritation
◊	◊	rapid/skipped heart beats	◊	◊	nervous with strangers	◊	◊	pain on intercourse
◊	◊	chest pains	◊	◊	nail biting	◊	◊	swelling of breasts
◊	◊	shortness of breath	◊	◊	difficulty making decisions	_____		# of pregnancies
◊	◊	swollen feet or ankles	◊	◊	lack of concentration	_____		# of births
◊	◊	armpits or groin swelling	◊	◊	loss of memory	_____		# of miscarriages
◊	◊	difficulty sleeping	◊	◊	lonely or depressed	_____		# of premature births
◊	◊	difficulty relaxing	◊	◊	frequent crying	_____		# of caesarean
◊	◊	excessive sweating	◊	◊	hopeless outlook	_____		# of abortions

◊ ◊ Comments or special problems:_____

What are you most sensitive to (e.g. noise, odors, light, pain)?

Describe an ideal day in terms of weather and temperature:

What are your fears?

Do you have any hobbies?

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams:

What is your Favorite color?

Least favorite color?

How is your energy? Is there any particular time of day when it is lower or higher?

(Girls only) What symptoms do you experience premenstrual?

How is your sexual interest/drive?

What do you most like to eat or crave?

What foods do you most dislike?

How is your thirst?

What temperature do you like fluids?

Are there any foods that you are sensitive to or allergic to?

Family History: Place an X in the appropriate column for any illness that you or your relatives have had

Illness	Child	Mother	Father	Sibling	Sibling	Sibling	Maternal GP	Paternal GP
Abnormal periods								
Alcohol/Drugs								
Allergies								
Anemia								
Arthritis/Gout								
Asthma								
Bleeding problems								
Cancer								
Diabetes								
Eczema								
Emphysema								
Epilepsy								
Frequent infections								
Heart trouble								
Hepatitis								
High blood pressure								
Kidney problems								
Mental illness								
Migraines								
Polio								
Pneumonia								
Prostate problems								
Psoriasis								
Rheumatic fever								
Stomach problems								
Stroke								
Thyroid problems								
Tuberculosis								
Ulcers								
Venereal disease								
Weight problems								