EXPERIENCE HEALING HOMEOPATHY
body mind heart spirit
Laurie Hoffman, CCH, RSHom(NA)
Tel: (845) 558-4293
www.ExperienceHealingHomeopathy.com
laynhoffman@gmail.com

YOUNG ADULT INFORMATION FORM

TODAY'S DATE ____________________

NAME ________________________________ BIRTHDATE _________ AGE ______ GENDER _______________
CELL PHONE ___________________________ E-MAIL ADDRESS ____________________________________

PARENT'S NAME____________________________ PARENT'S NAME________________________________

HOME ADDRESS ___________________________ HOME ADDRESS_______________________________

CITY_______________STATE ____ ZIP__________ CITY________________STATE _____ ZIP___________

WORK PHONE __________________________________WORK PHONE _________________________________
CELL PHONE ___________________________________CELL PHONE __________________________________

E-MAIL ADDRESS _______________________________E-MAIL ADDRESS _____________________________
OCCUPATION ___________________________________OCCUPATION __________________________________
SIBLINGS______________________________ AGE(S)____________________ GENDER(S)___________________
HOW DID YOU HEAR ABOUT THIS HOMEOPATH?____

PLEASE LIST YOUR HEALTH CONCERNS: (For both to fill out together)
1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

HEALTH HISTORY

Please check any of the following that apply and note when they started

__ ___ Acne: Type _______
__ ___ Allergies
__ ___ Anemia
__ ___ Appendicitis
__ ___ Arthritis
__ ___ Asthma
__ ___ Awkwardness
__ ___ Birth Defects
__ ___ Bladder/Urinary Tract Infections
__ ___ Cancer
__ ___ Chickenpox
__ ___ Chronic Ear Infections
__ ___ Colitis/Crohn's Disease
__ ___ Depression
__ ___ Developmental Delay
__ ___ Diabetes
__ ___ Distractibility
__ ___ Eating Disorder
__ ___ Eczema
__ ___ Exposure to Toxic Substances

__ ___ Frequent Antibiotic Use
__ ___ Frequent High Fevers (>102°F)
__ ___ Frequent Steroid Use
__ ___ Genetic Disorder
__ ___ German Measles
__ ___ Hayfever
__ ___ Headaches
__ ___ Heart Murmur
__ ___ Hepatitis
__ ___ Herpes/Cold Sores
__ ___ Hypoglycemia
__ ___ Impulsiveness
__ ___ Inactivity
__ ___ Inconsistency
__ ___ Irritability
__ ___ Jaundice
__ ___ Kidney Infections
__ ___ Left/Right Confusion
__ ___ Listlessness
__ ___ Lyme Disease

__ ___ Measles
__ ___ Mononucleosis
__ ___ Mumps
__ ___ Neurological Disorder
__ ___ Poor concentration
__ ___ Psoriasis
__ ___ Restlessness
__ ___ Rheumatic Fever
__ ___ Scarlet Fever/Scarlatina
__ ___ Seizure Disorder
__ ___ Social immaturity
__ ___ Talkativeness
__ ___ Tantrums
__ ___ Thumb Sucking
Until what age? ______
__ ___ Tuberculosis (TB)
__ ___ Tubes in ears
__ ___ Vaccine Reaction
__ ___ Whooping Cough

Review of Systems

Please indicate the following: **N= a condition has NOW** **P= a condition has had in the PAST**

Skin

Dry ________
Oily ________
Itching ________
Rashes ________
Hives ________
Fungal Infections ________
Bruises Easily ________
Slow Healing ________
Warts _____ Moles_____
Where ________________________
How Many ________
Nails Soft_____ Break_____

Head

Migraines_____ Headaches_____
Location of pain_________________
Worse: Light __ Noise__ Odors__
Head Injury ________
Describe________________________
Dizziness ________
Fainting ________
Seizures ________

Eyes

Vision Disturbance ________
Dryness_____ Tearing_____
Pain ________
Styes ________
Infections ________
Sensitive to Light ________

Ears

Discharge ________
Pain_____ Itch_____
Tubes inserted ________
Impaired Hearing ________
Ringing ________

Nose

Seasonal Allergies ________
Drainage ________
Color: Clear___ Yellow___ Green___
Texture: Runny_____ Thick_____
Post Nasal Drip ________
Stuffiness ________
Sneezing ________
Sinus Infections ________
Nosebleeds ________

Throat/Neck

Pain in Throat ________
Glands Enlarged ________
Difficult Swallowing ________
Change in Voice ________
Clears Throat Often ________

Mouth

Dryness___ Excessive Salivation___
Tongue: Sore___ Coated___
Canker Sores ________

Respiratory

Pneumonia ________
Bronchitis ________
Cough ________
Spit up Blood ________
Asthma ____ Wheezing_____
Shortness of Breath ________
Positive TB Test Ever ________

Cardiovascular

Heart Palpitations/Racing ________
Heart Defect ________
Murmur ________
High___ Low___ Blood Pressure
Leg Pains ____ Cramps____
Ankle Swelling ________
Cold Hands_____ Feet_____

Digestion

Bowel Movement ________
X per day: 1-2___ 2-3___ 3-4___ or
X per week: 1-2___ 2-3___ 3-4___
Texture: Dry___ Hard___
Wet/Loose___ Pellets___
Stools with Mucous___ Blood____
Hemorrhoids
Bleeding___ Painful___ Itching___
Fissures/Fistulas ________
Stool Incontinence ________
Very dark stools ________
Very light stools ________
Bowel Disease ________
Liver/Gallbladder Disease ________
Ulcer ________
Heartburn ________
Bloating ________
Belching ________
Gas / Flatus ________
Nausea / Vomiting ________
Pains / Cramps ________

Urinary

Difficult Urination ________
Painful Urination ________
Incontinence/Dribbling ________
Blood in Urine ________
Frequent Urination Day ________
Night ________
Frequent Bladder Infections ________
Bedwetting ________

Muscular/Skeletal

Back Pain ________
Pain in Muscles/Joints/Bones ________
Stiffness/Swelling ________
Muscle Weakness/Tremor ________
Numbness/Tingling ________
Shooting Pain ________
Paralysis ________
Any Side Worse: R___ L___
Ever Broken Bones?
Which__________________________
Ever Sprained Joints?
Which__________________________

GENERAL

Energy (scale of 1-10)
1=worst 10=best ________
Best Time of day___ Worst Time ___

Sleep

Good____ Bad____
Wake Easily: Y / N
Why: ____________ Time: ________
Frequently: Y/N
Difficulty Falling Asleep Y / N
Wake Refreshed Y / N
Snore Y / N Talk Y / N
Grind Teeth: Y/N Sleep Walk: Y / N
Preferred Sleeping Position_________
Nightmares: Y / N

Temperature

Sensitive to: Hot__ Cold__ Both___
Prefer: Inside___ Outside___
Warm blooded___ Cold blooded___
Best Season_____ Worst Season____

Perspiration

Sweat Easily: Y / N
Sweat Excessively: Y / N
Sweat Very Little: Y / N

Appetite

Excessive____ Good____ Poor____
Foods craves strongly_________
____
Foods dislikes strongly________
____
Prefers foods: Hot__ Warm__ Cold__
Thirst: Excessive __ Good__ Poor__
Prefer drinks: Very Hot___ Hot___
Warm__ Cold__ Ice cold__
Recent Weight Change: Y / N

Mother's Pregnancy

Nausea _____
Threatened miscarriage _____
High blood pressure _____
Pre-eclampsia _____
Back pain _____

Birth

Induction (Pitocin or Oxitocin) _____
Long or difficult labor or delivery _____
Please explain: ___________________
Prematurity _____
Child late _____
Cord around neck _____
Breech delivery _____
Caesarian section with prior labor _____
Scheduled caesarian _____
Rapid delivery _____
Drugs during labor _____
Please list: _____________

Neonatal

Rh incompatibility _____
Jaundice _____
Long time to produce breathing _____
Weight at birth _____
Height at birth _____
Colic _____
Much crying for no reason _____
Failure to thrive _____
Breast fed _____
How long? ______
Difficulties with nursing? _______

Development

Periods of separation from mother _____
If so, when: _____ How long: _______
Difficulties learning to walk _____
Difficulties learning to speak _____
Teething troubles _____

Vaccination
Fully vaccinated _____
Partially vaccinated _____
Please specify _____________________ _____
____
Not vaccinated
Any unusual vaccines _____
(e.g. yellow fever, Lyme, smallpox) _____
Vaccine reaction _____

Young Women Only
Frequent Yeast Infections _____
Vaginal Discharge _____
Age Period Began _____
Regular Periods Yes____ No____ _____
Flow: Heavy___ Medium___ Light___ _____
Length of Cycle ____ Days of Flow ____
Spotting _____
Cramps _____
PMS____ Endometriosis___ PID___
Fibroids______ Ovarian Cysts______
Ever Used Birth Control Pills? _____
How Long For?_____ How Long Ago?_____
Present Birth Control _________________

Young Men Only
Change in Force of Urine Stream _____
Difficulty Starting Urine _____
Do you do Self Testicular Exam _____
History of Undescended Testes _____
Pain / Lump in Scrotum _____
Discharge From Penis _____

All
Gender Change? _____

Past History
Hospitalization(s): ___________________________________
____
____

Serious Illnesses and Injuries: _________________________
____
____

Date of Last Physical Exam ___________________________

Date of Last Blood Tests______________________________

Personal Family History:
Please indicate to whom the condition applies by indicating N (now) or P (past) and to which relative it applies: mother, father, sister, brother, maternal or paternal aunt, uncle, grandmother or grandfather.

CONDITION	Parents	Siblings	Grandparents
Abnormal Periods			
Acne			
Alcoholism/Drugs			
Allergies			
Alzheimer's			
Anemia			
Arthritis/Gout			
Asthma			
Bleeding problems			
Cancer			
Type of Cancer:			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			

CONDITION	Parents	Siblings	Grandparents
Mental Illness			
Migraines			
Osteoporosis			
Pneumonia			
Psoriasis			
Rheumatic Fever			
Stomach problems			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Ulcers			
Venereal Disease			
Weight Problemns			
Other			

Immunizations

Small pox ___ year _____ Flu ___ year _____
Diptheria ___ year _____ Hepatitis ___ year _____
Polio ___ year _____ HPV ___ year _____
Tetanus ___ year _____
Mumps, Measles, Rubella ___ year _____

For young adult to fill out:
What do you want to most heal with homeopathic medicine?
____

How stressful is your current situation? (school, home, personal)
___ mild stress ___ moderate stress ___ severe stress

How committed are you to improving your current condition?
___ somewhat committed ___ committed ___ very committed

Please list your child's health care providers:
____
____

Please describe your child's living situation (e.g. divorced parents with joint custody) and any tension at home ____________
____

Please list all prescription and over the counter medications that s/he is currently taking:

Name of Medication	Date Started	Dosage/Frequency	Reason

List vitamins, minerals, herbs, homeopathic remedies that s/he is currently taking:

Name of Supplement	Date Started	Dosage/Frequency	Reason

Please list any severe or life-threatening allergies that your child has: _______________________________________

Please Explain____

Personal Habits

	hours/week (present)	hours/week (past)
Television		
Computer/Video Games		
Video/Movies		

	how much?	how long for?
Soda		
Sweets/Candy		
Coffee/Tea		

Any dietary restrictions or follow a particular dietary regimen? If yes, please describe:
____
____

Does s/he exercise regularly: Yes No What type:
____