



EXPERIENCE HEALING HOMEOPATHY  
body mind heart spirit

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TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

e-mail \_\_\_\_\_

OCCUPATION \_\_\_\_\_ IF RETIRED, PREVIOUS OCCUPATION \_\_\_\_\_

CHILDREN \_\_\_\_\_ AGE(S) \_\_\_\_\_ GENDER(S) \_\_\_\_\_

HOW DID YOU HEAR ABOUT THIS HOMEOPATH? \_\_\_\_\_

PLEASE LIST YOUR HEALTH CONCERNS:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

#### HEALTH HISTORY

Please CHECK ANY OF THE FOLLOWING THAT APPLY and NOTE WHAT YEAR THEY STARTED

_____ AIDS/HIV Infection _____	_____ Frequent Antibiotic Use _____	_____ Migraine Headaches _____
_____ Allergies _____	_____ Frequent Steroid Use _____	_____ Mononucleosis _____
_____ Anemia _____	_____ Gallbladder Disease _____	_____ Mumps _____
_____ Appendicitis _____	_____ German measles _____	_____ Nervous Breakdown _____
_____ Arthritis _____	_____ Giardia/Parasites _____	_____ Neurological Disorder _____
_____ Asthma _____	_____ Glaucoma _____	_____ Occupational Exposure to Toxins _____
_____ Attempted Suicide _____	_____ Gout _____	_____ Prostatitis _____
_____ Bursitis _____	_____ Hayfever _____	_____ Psoriasis _____
_____ Cancer _____	_____ Heart Disease _____	_____ Rheumatic Fever _____
_____ Cataracts _____	_____ Hepatitis _____	_____ Scarlet Fever/Scarlatina _____
_____ Chickenpox _____	_____ Herpes _____	_____ Seizure Disorder _____
_____ Chronic Fatigue Syndrome _____	_____ High Blood Pressure _____	_____ Sexually Transmitted Diseases _____ (chlamydia, warts, herpes, gonorrhea, syphilis)
_____ Chronic Ear Infections _____	_____ Hives _____	_____ Sleep apnea _____
_____ Colitis / Crohn's Disease _____	_____ Hypoglycemia _____	_____ Stroke _____
_____ Depression _____	_____ Jaundice _____	_____ Substance Abuse/Addiction _____
_____ Diabetes _____	_____ Kidney Infections _____	_____ Thyroid Disease _____
_____ Eating Disorder _____	_____ Kidney Stones _____	_____ TIA's (mini-strokes) _____
_____ Eczema _____	_____ Liver Disease _____	_____ Tuberculosis (TB) _____
_____ Edema (Fluid Retention) _____	_____ Low Blood Pressure _____	_____ Vaccine Reaction _____
_____ Emphysema _____	_____ Lyme Disease _____	_____ Whooping Cough _____
_____ Fibromyalgia _____	_____ Measles _____	

Other: \_\_\_\_\_

**Review of Systems**

Please indicate the following N= a condition you have NOW P= a condition you have 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 \_\_\_\_\_  
 TMJ \_\_\_\_\_  
 Dizziness \_\_\_\_\_  
 Fainting \_\_\_\_\_  
 Seizures \_\_\_\_\_

**Eyes**

Vision Disturbance \_\_\_\_\_  
 Dryness \_\_\_\_\_ Tearing \_\_\_\_\_  
 Pain \_\_\_\_\_  
 Styes \_\_\_\_\_  
 Infections \_\_\_\_\_  
 Sensitive to Light \_\_\_\_\_

**Ears**

Discharge \_\_\_\_\_  
 Pain \_\_\_\_\_ Itch \_\_\_\_\_  
 Impaired Hearing \_\_\_\_\_  
 Ringing/noises \_\_\_\_\_

**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**

Chest Pain \_\_\_\_\_  
 Heart Palpitations/Racing \_\_\_\_\_  
 Heart Disease \_\_\_\_\_  
 Murmur \_\_\_\_\_  
 High \_\_\_ Low \_\_\_ Blood Pressure \_\_\_\_\_  
 Varicose Veins \_\_\_\_\_  
 Phlebitis \_\_\_\_\_  
 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 \_\_\_  
 Size: Sm \_\_\_ Med \_\_\_ Lg \_\_\_  
 Color: Brown \_\_\_ Tan \_\_\_ Rust \_\_\_  
 Texture: Dry \_\_\_ Hard \_\_\_  
 Wet/Loose \_\_\_ Pellets \_\_\_  
 Stools with Mucous \_\_\_ Blood \_\_\_  
 Hemorrhoids \_\_\_\_\_  
 Bleeding \_\_\_ Painful \_\_\_ Itching \_\_\_  
 Fissures/Fistulas \_\_\_\_\_  
 Stool Incontinence \_\_\_\_\_  
 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 \_\_\_\_\_  
 Bedwetting \_\_\_\_\_

**Urinary (cont.)**

Frequent Urination Day \_\_\_\_\_  
 Night \_\_\_\_\_  
 Frequent Bladder Infections \_\_\_\_\_

**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 Broke Bones? \_\_\_\_\_  
 Which \_\_\_\_\_  
 Ever Sprain Joints? \_\_\_\_\_  
 Which \_\_\_\_\_

**Energy in general** (scale of 1-10)

1=worst 10=best \_\_\_\_\_  
 Best Time of day: AM or PM or \_\_\_\_\_  
 Worst time of day: AM or PM or \_\_\_\_\_

**Sleep**

Good \_\_\_ Bad \_\_\_  
 How many hours? \_\_\_\_\_  
 Wake Easily during night? Y/N \_\_\_\_\_  
 Why? \_\_\_\_\_ Time: \_\_\_\_\_  
 Difficulty Falling Asleep Y/N \_\_\_\_\_  
 Wake Refreshed? Y/N Grumpy? Y/N \_\_\_\_\_  
 Snore Y/N Talk Y/N \_\_\_\_\_  
 Grind Teeth Y/N Sleepwalk Y/N \_\_\_\_\_  
 Nightmares Y/N Dream a lot Y/N \_\_\_\_\_  
 Preferred Sleeping Position \_\_\_\_\_

**Temperature**

Sensitive to: Hot \_\_\_ Cold \_\_\_ Both \_\_\_  
 Prefer: Inside \_\_\_ Outside \_\_\_  
 Best Season \_\_\_ Worst Season \_\_\_

**Perspiration**

Sweat Easily Y/N \_\_\_\_\_  
 Sweat Excessively Y/N \_\_\_\_\_  
 Sweat Very Little Y/N \_\_\_\_\_

**Appetite**

Excessive \_\_\_ Good \_\_\_ Poor \_\_\_  
 Foods you crave strongly \_\_\_\_\_  
 \_\_\_\_\_  
 Foods you dislike strongly \_\_\_\_\_  
 \_\_\_\_\_  
 Prefer foods Hot \_\_\_ Warm \_\_\_ Cold \_\_\_  
 Thirst: Excessive \_\_\_ Good \_\_\_ Poor \_\_\_  
 Prefer drinks: Very Hot \_\_\_ Hot \_\_\_  
 Warm \_\_\_ Cold \_\_\_ Ice cold \_\_\_  
 Recent Weight Change Y/N \_\_\_\_\_

**Women Only**

Date of Last Pelvic Exam \_\_\_\_\_  
 Date/Results of Last Pap Smear \_\_\_\_\_  
 Ever Have an Abnormal Pap Smear? \_\_\_\_\_  
 DES Exposure \_\_\_\_\_  
 Sexually Transmitted Disease \_\_\_\_\_  
 History of Sexual Abuse \_\_\_\_\_  
 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 \_\_\_\_\_  
 Change in Sex Drive \_\_\_\_\_  
 Painful Intercourse \_\_\_\_\_  
 Pregnancies (number) \_\_\_\_\_  
 Childbirth (number) \_\_\_\_\_  
 Complications \_\_\_\_\_  
 Miscarriages (number) \_\_\_\_\_  
 Abortions (number) \_\_\_\_\_  
 Impaired Fertility \_\_\_\_\_  
 Have You Had A Hysterectomy? \_\_\_\_\_  
 Age at Menopause \_\_\_\_\_  
 Vaginal Dryness \_\_\_\_\_  
 Hot Flashes \_\_\_\_\_  
 Do You Do Self Breast Exams? \_\_\_\_\_  
 Mammograms (number) \_\_\_\_\_  
 Date of Last Mammogram \_\_\_\_\_

**Men Only**

Date of Last Prostate Exam \_\_\_\_\_  
 Prostate Enlargement \_\_\_\_\_  
 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 \_\_\_\_\_  
 Painful Intercourse \_\_\_\_\_  
 Difficulty with Erections \_\_\_\_\_  
 Change in Sex Drive \_\_\_\_\_  
 Impaired Fertility \_\_\_\_\_  
 Sexually Transmitted Diseases \_\_\_\_\_  
 History of Sexual Abuse \_\_\_\_\_

**Gender change**

When: \_\_\_\_\_  
 Describe: \_\_\_\_\_

**Past History**

Hospitalization(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Serious Illnesses and Injuries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_  
 Date of Last Blood Tests \_\_\_\_\_  
 Date of Last Colonoscopy \_\_\_\_\_  
 Date of Last DEXA (bone density test) \_\_\_\_\_

**Personal Family History:**

Please check the “yes” box next to each condition that applies to you or one of your family members. Please note whether the condition applies to you by writing the word “self” in the relation column or mother, father, sister, brother; paternal or maternal aunt, uncle, grandmother or grandfather. Please indicate if the condition exists now (N) or in the past (P).

CONDITION	YES	RELATION	PAST (P) / NOW (N)
Alcoholism/Drug Addiction			
Allergies			
Alzheimer’s			
Anemia			
Arthritis			
Asthma			
Birth Defects			
Cancer			
Type of Cancer?			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Learning Disability			
Mental Illness			
Mental Retardation			
Osteoporosis			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Other			

Please list the names of your health care providers: \_\_\_\_\_

Do you have a specific spiritual practice? Y N If so, please describe it \_\_\_\_\_

Is there anything a health provider should know in relation to this? \_\_\_\_\_

Please list all prescription & over the counter medications that you are currently taking: **Medication, purpose, dose & date started.**

Name of Medication	Date Started	Dose/Frequency	Reason

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking: **Medication, purpose, dose & date started.**

Name of Supplement	Date Started	Dose/Frequency	Reason

Please list any severe or life-threatening allergies: \_\_\_\_\_

Please explain: \_\_\_\_\_

**Personal Habits**

Please indicate which substances, if any, pertain to you N= use NOW P= used in the PAST

Substance	N / P	How Much?	How Long?	Substance	N / P	How Much?	How Long?
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				Recreational Drugs			

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

\_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ What type? \_\_\_\_\_

\_\_\_\_\_