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Classical Homeopathy for Mind, Body, and Soul
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New Patient Questionnaire

Today's Date: _____ Date of Birth: _____

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____

Email address:_____

Referred by: _____

Primary Care Physician: _____

Previous Homeopathic treatment? _____

Gender: _____M _____F Marital Status_____ Height _____Weight _____

Occupation: _____

What makes you seek homeopathic treatment at this time?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What do you feel may be contributing to these issues? _____

_____

_____

_____

MEMBERS OF YOUR HOUSEHOLD:

Name	Age	Relationship

MEDICATIONS

Drug Name	When started	Dose/Frequency	For?

MEDICINAL HERBS, VITAMINS, SUPPLEMENTS, HOMEOPATHIC REMEDIES

Name	When started	Dose/Frequency	For?

Allergies (Environmental, medications, etc.) Please describe reaction if applicable:

_____

_____

_____

_____

HEALTH HABITS

How many times each week do you exercise for 20 minutes or more?_____

How do you exercise? _____

_____

_____

How do you relax? _____
_____
_____
Do you have an active spiritual practice?_____
_____
Do you enjoy your work?_____ Hours worked/week_____
Quality of relationship with significant other? _____
_____
Other support systems? _____
_____
_____

Do you use . . .

Coffee No Yes Amount _____
Tea No Yes Amount_____
Alcohol No Yes Amount _____
Tobacco No Yes Amount _____
Recreational drugs No Yes Type/Amount _____
Are you concerned about your drug/alcohol use? _____

HOSPITALIZATIONS and/or SURGERY **DATE**

_____
_____
_____
_____
_____

OTHER MEDICAL ILLNESSES, ACCIDENTS, INJURIES?

_____
_____
_____
_____
_____

BIRTH HISTORY

Place of Birth _____ _____ Home _____ Hospital _____ Other
How was your mother's health while she was pregnant with you? Any complications during her labor with you?_____
_____
_____
_____

MEDICAL STUDIES

Have you had any of the following? If so, when and why?
Chest X-ray? _____ TB Skin Test?_____
MRI/CAT Scan? _____
Ultrasounds _____
EKG? _____
CBC/Blood Chemistry _____
Other diagnostic studies? _____
Eye exam _____ Dental exam _____

What experiences in life have affected you deeply? _____
_____ _____
_____
_____
_____
_____

What are you most sensitive to? (noise, odors, lights, pain, heat, cold, etc?)
_____
_____
_____
_____

What are your fears and anxieties, past or present? (i.e., situations, people, animals, events, etc)
_____
_____
_____
_____

What do you enjoy in life? Activities? Hobbies?
_____
_____
_____

How is your sleep? What is your favorite sleep position?
_____
_____
_____

How is your energy? Are there times when it is lower or higher?
_____
_____
_____

How is your sexual interest/drive?

_____

_____

Please describe ANY dreams that you recall, vivid or recurrent, or themes of dream. (please use back of sheet or another piece of paper if needed)

_____

_____

_____

_____

_____

_____

_____

What specific foods or flavors do you most LIKE to eat, crave, or enjoy?

_____

_____

What specific foods or flavors do you most DISLIKE?

_____

_____

Are there any foods to which you are sensitive or allergic? If so, please describe reaction?

_____

_____

_____

What is your natural body temperature – i.e., are you hot-natured, cold-natured, or in-between?

_____

What are your favorite drinks and at what temperature do you enjoy them (hot, warm, icy, etc)?

_____

_____

Type of weather, temperature, and environment you most dislike?

_____

_____

Please describe what you were like as a child? _____

_____

_____

_____

If you have been bothered by any of these problems, please mark (X) for yes:

___ Headaches
___ Dizzy spells
___ Loss of balance
___ Blackouts/fainting
___ Back pains
___ Neck lumps/swelling

___ Wear glasses
___ Blurry vision
___ Eyesight worsening
___ See double
___ Eye pains/itching

___ Head colds
___ Nose bleeds
___ Sore throats
___ Difficulty swallowing
___ Hoarse voice
___ Wheezing/gasping
___ Frequent coughing
___ Cough up phlegm
___ Chest colds

___ Runny nose
___ Sneezing spells
___ Sinus problems
___ Recurrent colds/flu

___ Nervousness/anxiety
___ Nail biting
___ Difficulty making decisions
___ Lack of concentration
___ Loss of memory
___ Lonely or depressed
___ Frequent crying
___ Difficulty relaxing
___ Angered easily
___ Shy or sensitive
___ Annoyed by little things

___ Indigestion
___ Frequent belching
___ Nausea
___ Vomiting
___ Abdominal pain
___ Constipation

___ Loose stools
___ Black stools
___ Grey or whitish stools
___ Pain in rectum
___ Itching rectum
___ Bloody stools

___ Frequent urination
___ Urinary burning

___ Aching muscles or joints
___ Swollen joints
___ Back or shoulder pains
___ Weakness in arms or legs
___ Painful feet
___ Trembling
___ Numbness
___ Leg cramps

___ Skin rash
___ Scalp problems
___ Itching/burning skin

___ Bruise easily

MEN ONLY

___ Burning
___ Discharge
___ Painful testicles
___ Swelling testicles

WOMEN ONLY

___ Missed period
___ Menstrual issues
___ Bleeding between periods

___ Bearing down feeling
___ Discharge from vagina
___ Genital irritation
___ Painful intercourse
___ Breast swelling

___ # of pregnancies
___ # of births
___ # of miscarriages
___ # of premature births
___ # of caesarians
___ # of abortions

Comments or special problems: _____

_____

_____

_____

_____

_____

_____

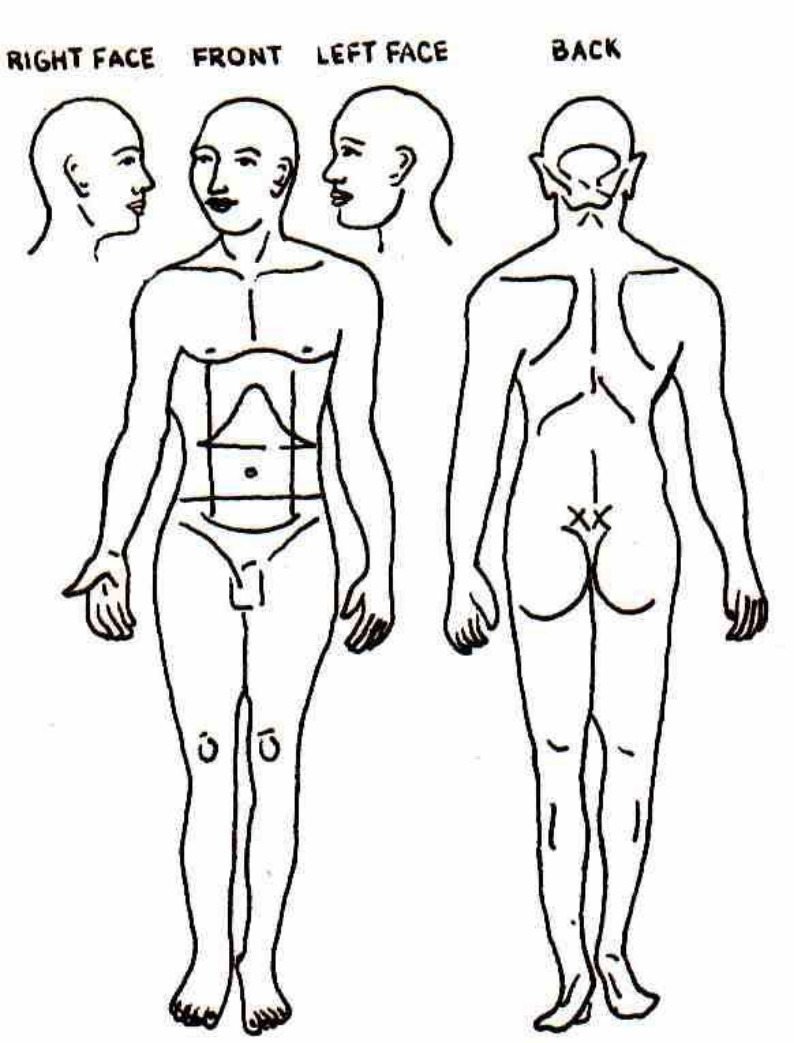
_____

_____

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

Illness	**Self**	**Father**	**Mother**	**Brothers**	**Sisters**	**Child #1**	**Child #2**	**Child #3**	**Grandparents**
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									

Please mark in the figure below, the locations of physical symptoms; please also write the exact sensation or type of pain you experience at those spots. For example, if you experience throbbing pain on the right side of your head, please mark as shown.



THANK YOU!!!