Homeopathic & Nutrition

Patient History Form

Name:

Date of Birth Place of Birth

Time of birth (if known) Age

Address

Phone: Email:

Marital Status: Single Married Defacto Widowed Divorced

Children and ages:

Occupation

Are you currently taking any other nutritional supplements, herbal preparations, homeopathic remedies?

Any known allergies:

Sometimes it is helpful for me to have a look at your Natal Astrology chart in your case.

This is not compulsory but an option.

Do you consent to having a chart done as part of your case? YES NO

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REVIEW OF SYSTEMS

List and describe any specific problems or diagnosed conditions.

NERVOUS SYSTEM: Dizziness, numbness, weakness, headache, blurred vision, visual loss.	
EAR, NOSE & THROAT: hearing, swallowing, sinus problems, tonsils, adenoids etc.	
GASTROINTESTIAL: Appetite, pain, Indigestion, constipation, diarrhoea, abdominal pain	
EMOTIONAL: Eating disorder, bipolar disease, depression, anxiety, OCD, ADHD, schizophrenia, trauma – PTSD, childhood trauma.	
Lungs: Asthma, chronic cough, allergies etc	
Heart: Shortness of breath, chest pain, irregular heartbeat, high blood pressure	
BREAST: Pain, lump, tenderness, discharge Breastfeeding, Breast cancer	
URINARY: Loss of urine, frequent infections, blood in urine, kidney stones	
REPRODUCTIVE: **FEMALE**: Menses commence, problems with periods, regularity, painful, blood loss, pregnancies, births, pregnancy losses, perimenopause, menopause etc. PCOS, Infertility, Fibroids etc. **MALE**: Testicular pain/masses; abnormal penile discharges; sexual difficulties; erectile/infertility issues; enlarge prostate; venereal diseases	

SKIN: Rashes, persistent sores, worrisome moles, lumps, pigmented patches on skin or in skin folds, easy bruising	
BONES, JOINTS & MUSCLES Sore joints, weakness, heat, swellings, colour changes, movement, pain.	
ENDOCRINE: Excessive hair growth, hair in abnormal location, weight gain/loss, skin pigment changes, thyroid problems, lack of regular cycles, diabetes, glucose intolerance	
GLOBAL: Fatigue, sleep disturbance, feeling of loss of well-being, anaemia, elevated cholesterol or triglycerides.	
OTHER: Are there other current health complaints not already covered?	

Please provide as much information as possible to any conditions above: eg. How long have you had this, what symptoms do you get, what treatments have you tried? Etc.

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Local Medical Practitioner:

Contact Details:

Current medications

Surgeries/investigations?

Covid Vaccines Yes No.

If so, which brand did you have? AstraZeneca Pfizer Moderna Other:

How many doses did you have?

Did you have any changes in your health after? Yes No.

If yes, please explain

LIFE STYLE

Do you exercise? Yes No

How many caffeinated beverages (coffee, tea, soft drink) do you consume daily?

Do you smoke cigarettes? Yes No If yes, how many each day?

Do you drink alcohol? Yes No If yes, how many daily?

SLEEP

What is your sleep quality like?

How many hours?

Do you feel refreshed in the morning?

Do you wake frequency through the night – if so what times and how often.

Do you struggle getting back to sleep?

How many hours sleep do you normally get?

FAMILY HISTORY

Do you have a family history of breast, ovarian or bowel cancer? Yes No

If yes, who and at what age?

Please list any illnesses including mental illness or diseases (past or present)

Father

Mother

Siblings

Grandparents (Mothers side)

Grandparents (Fathers side)