Please fill out this form completely
& bring it to your initial appointment.
For Skype or Phone appointments, send form back either by email or standard mail
AT LEAST 7 DAYS BEFORE YOUR APPOINTMENT.

Mail to:

Homeopathic Centers of America
716 Jaster Street
Green Bay, WI 54302

Office location will be provided when appointment is scheduled.

Email: **info@MyHCA.org** (put in the reference line "New Patient Forms")

Thank You,
the HCA Team

The Homeopathic Centers of America
Healing the world one person at a time!
(920) 558-9806
www.MyHCA.org

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PLEASE READ THIS FIRST BEFORE FILLING OUT THIS FORM

You have come here to get well. We are here to make the best possible recommendations for you. In order to do that, we depend upon your cooperation. THE HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful selection, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history, as well as your mental make-up.

In order to find out all about you, we shall be asking many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is not important. Even something that you may think is not connected with your troubles may be the most important factor in deciding the correct homeopathic remedy. That is why you must be free and frank and give us the fullest possible information on each point. Please read each question carefully, think, and if necessary, consult someone close to you and then answer the question completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential.

THIS QUESTIONNAIRE HAS 10 PARTS:

1. What supplements and drugs you are currently taking and why.
2. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
3. History of your present illness.
4. About all the parts of your body.
5. The factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
6. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank, open and honest.
7. About your sleep and dreams.
8. For children or how you were as a child.
9. In this part you are given instructions about how to report each of your health concerns. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.
10. Questions to help us keep you healthy in the future.

CONFIDENTIAL
CLIENT DEMOGRAPHIC INFORMATION

Name:_____ To be called:_____

Date of Birth:_____ Age:_____ Gender: M F Gender you identify with: ____

Marital Status:_____ Spouse/Significant Other's Name:_____

Spouse's Age:_____ Your Anniversary Date:_____ # Children:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Work:_____ Home:_____ Cell:_____

Email address:_____ Skype (if applicable):_____

Do you Text? Y N Preferred Method of contact:_____ OK to leave messages? Y N

In case of Emergency, contact:_____ Phone:_____

Occupation:_____ Employer:_____

Education Level: ( ) High School ( ) Some College ( ) Bachelor's Degree ( ) Post-Graduate
( ) Professional ( ) Other:_____

I take: ( ) Medical Drugs ( ) Natural Supplements

Primary Care Physician:_____ City/State:_____
Is he/she aware you take natural supplements? ( ) Yes ( ) No

Allergies/Sensitivities:_____

_____

What is your goal for your care with us?

How did you hear about *The Homeopathic Centers of America*?_____

Informed Consent

Dr. Ronda Behnke often publishes articles based on the cases solved in her practice. As such, she may take pictures of a rash or such. A picture of you will also be taken for charting purposes and to refer back to if needed; this will never be used in an article without your expressed written consent; pictures of rashes, however, may be used so long as the reader would not be able to identify you (so no face pictures will be used).

Dr. Ronda may also record the session for her records and so that she can refer back to the recording when analyzing your case. This recording is for office use; however, Dr. Ronda may share the recording with other Homeopaths so they may learn from the interview process and/or to help others in case analysis. **If you do not want your recording shared with other Homeopaths, then initial here:_____**

Regarding your **picture(s)**, please check which of the following you authorize Dr. Ronda or her staff to do:

( ) Take and use any picture taken for office purposes ONLY.

( ) Take and use any pictures taken for publishing purposes so long as the reader will not be able to learn my identity from the picture(s). Pictures can also be used for office purposes.

If this case is published, please use my name as:

( ) My actual first name with last initial, or just the actual first name.

( ) My actual initials.

( ) Use a fictitious name.

By signing here, you authorize Dr. Ronda Behnke and/or the *Homeopathic Centers of America* to utilize the photos and/or recording as you have noted above. You may change or modify your selections at any time by writing your request or filling out another of this form.

_____ _____

Signature Date

Disclaimer

Ronda Behnke is a Naturopathic Doctor and Classical Homeopath. In the state of Wisconsin, Naturopathic Doctors and Homeopaths are not licensed to diagnose or treat health conditions or prescribe supplements, or to say that supplements "cure" health conditions. If you follow any recommendations made during evaluations, you do so under your own discretion. No supplement will be recommended without you being advised of its studied benefits and risks. It is highly advised that you make your health care practitioner or medical doctor aware of any natural supplements you are taking.

Also, Dr. Ronda Behnke will make no adjustments to your medical treatments or drug regimen. It is your choice if you stop or change your medical care. Dr. Ronda **strongly** recommends that you discuss drug changes with the prescribing physician of that drug PRIOR to making any changes.

If you are a representative from a government agency doing an inspection, you must disclose this information prior to your appointment. Signing this form below indicates you are not from a government agency.

Cancellation/No-Show Policy

(As per the *Office Policies*—the last two pages of this form)

I understand that if I need to cancel or change my appointment I need to do so within 48 hours of my appointment time. I understand I can call and leave a message on the voicemail at 920-558-9806 to do this; TEXT AND EMAIL CHANGES ARE NOT PERMITTED. I understand that Dr. Ronda will call to confirm the receipt of the message shortly after receiving it. If I do not hear back from Dr. Ronda within a few hours of leaving my message I will call and leave another message. It is my job to ensure my message is received. If my appointment is for a Monday, I would need to call by the scheduled time on Thursday (ex: if your appointment is for 11 a.m. on Monday, you need to call by 11 a.m. on Thursday). It is also my responsibility to know the correct time of my appointment—if I have any doubt about my scheduled time, I will call to confirm.

I understand that if it is less than the 48 hours and I am sick or unable to keep my appointment for **ANY** reason, I will be charged for the session should Dr. Ronda Behnke deem my excuse is not reasonable for the cancellation or no-show. I understand that I will not be seen for any future appointment until this debt is paid and that Dr. Ronda Behnke will submit my balance to a credit agency after 3 months if the balance is not paid in full, unless other arrangements have been made.

I understand and accept these guidelines and notices. With my signature, I agree to the above terms and conditions.

Print name of Client Signature of client or guardian Date

Medication List

						For Office Use Only
Today's Date	**Drug Name**	**Rx/OTC**	**Dosage**	**Reason Taking**	**How Long**	**Notes**

Name:_____

Personal Supplement List

					For Office Use Only	
Date	**Product Name**	**Manufacturer**	**Dosage**	**Reason Taking**	**Notes**	**OK/Not**

Name:_____

Personal Supplement List

					For Office Use Only	
Date	**Product Name**	**Manufacturer**	**Dosage**	**Reason Taking**	**Notes**	**OK/Not**

Name:_____

PREVIOUS DISEASES & DRUGS USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homeopathic care takes into account all these details of the past and thus removes all the weak points thereby your body is strengthened. To do this, it is necessary for us to know about all the ailments from which you have suffered in the past and the treatments you have taken.

In the list below, circle around names of ALL major illnesses you have so far suffered and on the next page, give its relevant details.

Typhoid Cholera Food poisoning/Stomach Flu Worms Diarrhea Dysentery	Measles German Measles Chicken Pox Small Pox Mumps Whooping Cough	Malaria Jaundice Any Liver, Spleen or Gallbladder Disease(s)	Miscarriage Abortion Currettings (D & C) Sickness during pregnancy Prolapse of uterus
Malnutrition Rickets Rheumatism Back ache	Any venereal/sexually-transmitted disease like Syphilis, Gonorrhea, HIV, etc.	Any heart troubles High blood pressure Dizziness	Kidney or Bladder Trouble Diabetes Prostate troubles
Drugs used: Antibiotics Birth Control (medicated) Chemotherapy/Radiation Corticosteroids Laxatives	Diphtheria, Septic Tonsils, Adenoids Recurrent infections—Sinusitis Bronchitis Eosinophilia Cold, Fever, Chills Pneumonia, Bronchitis Asthma, Pleurisy, Tuberculosis		Any serious shock, grief, disappointments, fright, mental upset, depression, nervous breakdown, suicidal thoughts, suicidal attempts, etc. Addictions—to what?
Chronic headaches Numbness, Cramps, Epilepsy Polio, Paralysis, etc. Meningitis Any lumbar puncture done	Any major accidents, injuries to the body or head Any occasion of unconsciousness Any major bleeding from any part of the body		Skin diseases like Pimples, Boils, Ringworm, Fungus, Scabies, Eczema, Psoriasis, Herpes, Hives, Allergy, etc. Ulcers on any part of the body

Diseases suffered from	Approximate Age	Duration	Did you completely recover?	Medicines & Treatments Taken	Any other particulars?

Any extra remarks or information

Mention any drugs, tonics, stimulants, etc. that have been used by you at any time in your life.

FAMILY INFORMATION

List of Major Diseases		Relationship	Alive or Dead	Age	Diseases Suffered	Cause of Death
Anemia Cancer Diabetes Mental Illness Alzheimer's Disease Dementia Rheumatism Tuberculosis Pleurisy Leprosy Seizures Bleeding Tendencies Urticaria (Hives) Eczema Asthma Paralysis Hypertension Heart trouble Kidney disease Liver disease Food intolerances Allergies Birth defects Autism Developmental Abnormalities		**Paternal Grandfather**				
		Paternal Grandmother				
		Maternal Grandfather				
		Maternal Grandmother				
		Father				
		Mother				
		Diseases Suffered				
		Paternal Uncles				
		Paternal Aunts				
		Maternal Uncles				
		Maternal Aunts				
		Cousins				
		Did any relatives have troubles similar to yours? Who?				

Regarding brothers and sisters (including those who died), provide information about them in the table below, indicate your position by writing "SELF".

#	Brother/Sister	Alive or Dead	Age	Diseases suffered
1				
2				
3				
4				
5				

RELATIONSHIPS

Give a clear-cut picture of your relationships with each of your family members, friends and associates at work.

Spouse or Significant Other	
Children	
Parents	
Siblings	
Supervisor/Boss	
Co-Workers or Classmates	
Friends	
Others in your life	

PERSONAL HISTORY

About your birth:

* Did your mother have any problems during pregnancy? ( ) Yes ( ) No ( ) Don't know
* Did your mother take any drugs during pregnancy? ( ) Yes ( ) No ( ) Don't know
* Was there any difficulty about your birth? ( ) Yes ( ) No Give details is Yes:

At what age did you start:

Teething	
Sitting	
Standing	
Walking	
Speaking	

Urine control, bed-wetting, etc.	
Eating indigestibles like chalk, earth, pencils, etc.	
Any other problems about your growth and development?	

Did you have any of the following bites: ( ) Dog ( ) Cat ( ) Rat ( ) Snake ( ) Scorpion ( ) Spider ( ) Other:_____

Did you take anti-rabies or anti-venom or any other treatment? ( ) Yes ( ) No ( ) Don't know

Vaccinations & Inoculations:

( ) I have never been vaccinated.

Was there any reaction or particular trouble after any vaccination or inoculation? ( ) Yes ( ) No
If YES, please give details.

If married, how is the health of your spouse?

Your children:

How many Pregnancies: ___ Births: ____ Miscarriages:_____ Stillbirths:_____ Abortions:____

How many vaginal deliveries:_____ C-Sections:_____ Premature:_____ Full-Term:_____

Difficulties during pregnancies & drugs used:

Mention the ages of your children and their condition of health or reason for death.

Child's Name	Male/Female	Age	Diseases Suffered	Alive/Dead

Your Current Personal Information:

Height:_____ Weight:_____ Ideal Body Weight:_____ Skin Type:_____

Do you consider yourself to be Highly Sensitive?_____

What time of day and day of the week do you feel your best?_____

Worst?_____

Surgeries & Operations:

Operation Type or Organ Removed	When	Why	Any Problems?
Ex: Tonsils removed	Age 12	Too many sore throats	Nausea after waking up

Your Diet:

On a separate sheet of paper, for 5 days in a row, write down ALL the foods and drinks you consume. Also write down portion size, such as "2 bananas," whether or not the food was organic, and if you had any reaction to those foods or drinks.

Is your diet: ( ) Vegetarian ( ) General/Non-Veg ( ) Other:_____

Please check the appropriate boxes regarding these foods:

	Crave	**Dislike**	**Disagrees**		**Crave**	**Dislike**	**Disagrees**
Bitter				Eggs			
Salty				Spicy			
Sweets				Meat			
Sour				Fish/Seafood			
Bread				Cabbage			
Butter				Onions			
High Fat Foods				Milk/Dairy			
Coffee				Fruits			

Describe any reaction you have to any foods or drinks and what happens when foods "disagree" with you:

How do you prefer your food: ( ) hot ( ) cold ( ) room temperature ( ) doesn't matter

ORIGIN OF CAUSE: Can you trace the origin of the present illness to any particular circumstance, illness, accident, incident or mental upset? (e.g. shock, worry, errors in diet, overexertion, exposures). "Never been well since….."

1. BRAIN, NERVOUS SYSTEM & MENTAL PROCESSES

Do you experience dizziness or vertigo?

Do you ever feel faint?

Do you get headaches or migraines? How often?

How is your concentration? Is it worse at any particular time of day?

Do you experience weakness, tremors or trembling in any part of your body? When and where?

Do you experience numbing, tingling, paralysis, tics or twitches in any body part? Where and when?

Do you ever have cold hands and feet? Even in warmer months?

2a. BONES, JOINTS & MUSCLES

History of broken bones:

Do you have any pins or metal in any part of a bone or joint?

So you have rheumatism or arthritis? If so, where?

Describe any injuries to your joints, bones or muscles.

2b. SPINE & NECK

How is your posture?

Any history of scoliosis? At what age were you diagnosed? How was it treated?

History of injuries to the neck and back.

2c. ARMS & LEGS, HANDS & FEET, SHOULDERS & HIPS

Do you get swelling around your ankles? Describe.

Do you have bunions, corns or callus formations on your feet? Where?

Any problems with either shoulder?

Any problems with either hip? Hip replacements?

Any problems with the knees? Knee replacements?

3. HEART, BLOOD & CIRCULATION

Do you or have you had anemia? When?

History of blood clots:

Do you have or a family history of bleeding disorders?

Do you have any troubles with your heart or chest?

Do you have times of increased heart rate? When?

Do you have times where it feels as if your heart has an irregular rhythm or skips a beat? When?

Any history of a heart murmur?

Have you ever had angina (heart pain) or a heart attack? When?

Do you bruise easily? Where do you bruise easily?

4. LUNGS, BREATHING & COUGH

Is there any difficulty in breathing? Describe.

Is there any wheezing? Describe.

Do you have a cough? Is it more at any particular time?

Have you ever had ( ) pneumonia, ( ) pleurisy, ( ) collapsed lung, ( ) bronchitis?

Do you often breathe through your mouth instead of your nose? How often and when?

5a. STOMACH, APPETITE & THIRST

How is your appetite? When are you hungry?

What happens if you wait too long to eat?

How much thirst do you have?

Any particular time you are especially thirsty?

5b. LIVER & GALLBLADDER

Have you ever had or currently have a disease of the liver such as cirrhosis, hepatitis or jaundice? When?

Do you experience pain or discomfort on the right side under your ribcage?

History of gallstones.

6. COLON, BOWELS & STOOL

Do you have any problems regarding your stools?

When and how many times a day do you pass stools?

When is it urgent?

Do you have any troubles with your bowel movements? Do you have to strain for stool? Even if it is soft?

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas or belching?

Does your abdomen experience much rumbling or audible sounds? Describe.

7. KIDNEYS, URINARY BLADDER, URINATION & URINE

Any problems about urine?

Any strong smell? What like?

Do you have any trouble before, during or after passing urine?

Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling, etc.

Any involuntary urination or bed-wetting? When?

History of bladder infections, Urinary Tract Infections (UTIs) or kidney infections.

Any history of kidney stones? Describe.

8a. SEXUALITY (GENERAL)

Did you have a delay in reaching puberty?

Were you sexually abused or raped? If so, at what age and by whom?

Any excessive indulgence in sex in the past or present? Any effect on your health?

Any particular feelings or symptoms that appear before, during or after sexual intercourse?

Do you suffer from any sexual disturbance?

Any habit (like masturbation) in the past as well as the present? How often?

Do you have increased desire or decreased desire for sex?

What is the method of family planning that you use (contraception)?

Do you experience any side effects from this method?

8b. FOR MEN

Any difficulty in erection? Wanted or unwanted erection, weak or failing? Describe.

Any other trouble in sex? Describe.

Any unwanted penile discharge? Describe.

8c. FOR WOMEN

Are you pregnant now or possibly pregnant?

Describe any trouble you have with your breasts.

Have you ever had ( ) ovarian cysts ( ) endometriosis ( ) polapsus of uterus ( ) uterine polyps?

Menstrual Cycle (if applicable):

How are the periods: regular or irregular?

At what age did you start menstruating? Was there any trouble then?
How long is your cycle (beginning of period to the beginning of the next period)?

What is your average number of days of flow?

Regarding menstrual flow, is there any change now in quantity, color, smell or consistency?

Are the stains difficult to wash?

Have you noticed any variation in quality and quantity of flow during menses? How and when?

Do you suffer in any way before, during or after menses? If so, describe.

Is there any white discharge? If so, mention the nature, consistency and smell of discharge.

When and under what circumstances is the white discharge more or less? Has the discharge any relation to menses?

What is the general effect of this discharge on your general feeling or any of your symptoms?

Any itching, excoriation, etc. due to discharge?

How do you feel about your period?

Menopause (if applicable):

Where are you in the menopausal cycle? ( ) Done ( ) In the middle ( ) Just beginning

What symptoms did you suffer during menopause?

Do you feel internal parts coming down?

Do you have vaginal dryness?

9a. SWEAT/PERSPIRATION, FEVER, CHILL

How much do you sweat?

Where and on what part do you sweat the most?

Do you perspire on the palms and/or soles?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linens, etc?

What is the smell? Ex. foul, pungent, sour, like urine.

What color does it stain the clothing? Is the stain easy to wash off or difficult?

Any symptoms after sweating?

When do you get a fever or chill? What brings it on?

Do you experience any sense of heat or cold in any part of the body at any particular time?

Do you have burning or heat in your palms or soles?

9b. HAIR, SKIN & NAILS

Are there any complaints of the SKIN such as itching, eruptions, ulcers, warts, corns, etc. Describe its nature.

Any change in color of the skin or spots of any kind on the body? Where.

Is there any complaint or abnormality of the NAILS or skin around the nails?

Do you chew your nails or the skin around them?

Is there any complaint with the HAIR such as falling out, graying, receding, dandruff, dryness, etc.?

Do wounds heal slowly? Do wounds tend to form pus?

Do you have a tendency to bleed even from small wounds?

10a. EYES & VISION, EARS & HEARING

Do you wear contacts or glasses? For what reason?

Does your eyesight change at dusk and/or dawn?

How is your hearing?

Do you experience sounds in your ear(s) such as ringing, roaring, etc.? Describe.

What is your history regarding ear infections?

10b. THROAT, SPEECH, TONSILS & SWALLOWING

Any difficulties swallowing? With what do you have difficulty?

Do you have frequent episodes of throat pain?

Do you have frequent clearing of the throat or hawking?

Any trouble with speech, such as stammering?

10c. SINUSES & SENSE OF SMELL

Do you have any troubles with your sinuses? Describe:

History of sinus infections.

Do you have or have had: ( ) nasal polyps ( ) frequent nose bleeds ( ) deviated septum

11. MOUTH, TEETH, TONGUE, GUMS & TASTE

How are your teeth?

To what are your teeth sensitive? Which teeth?

Do you feel any change in your taste and feelings in your mouth? Bad breath? Describe.

How are your gums?

How are your lips? (peeling, chapped, etc.)?

Do you ever get cold sores, fever blisters or mouth sores? When?

How is your sense of taste? Is there a lingering taste in your mouth? Describe it.

Do you get/have cracks at the corners of your mouth?

12. OTHER GENERAL SYMPTOMS

FACE & FACIAL EXPRESSION: Any troubles?

If you have pains, do they shift? In what direction do they extend?

Is there any abnormality, sweating, numbness, paralysis, etc. in any part of the body?

Are your troubles one-sided? Which side?

Do they proceed from one side to the other? Or do they alternate or shift?

How many days on average do you miss school or work due to illness per year?_____
Is this more or less than last year? _____

Do you have a recurring infection or a chronic one? If so, where and for how long?

Do your colds come on suddenly or slowly?

FACTORS THAT AFFECT YOU

Below are the list of things that you are exposed to; each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of these factors? In what way do they affect you?

For instance: take the factor "sun". Supposed by going in the sun you get a headache then write "Headache" opposite to "sun". Another example: if in hot weather you feel uneasy, then write "Uneasy" opposite to "Hot Weather" in the column.

In this way, write the effect of each of the factors on you. Especially note those that have an effect on your main complaints. For example, if your main complaint is Asthma and this is worse when lying on your back, then opposite to "lying on the back" write "asthma becomes worse."

Sometimes one factor can make you feel worse in some respect and better in a different respect. For instance, cold air may cause headache but makes you feel better in general. If this is so, please mentation this difference clearly. There is more space to write after the Factors.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

	Effect
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of seasons	
Thunderstorms	
Covering	
Warm bath	
Sun	
Cold bathing	
Drinking	
Sitting	

	Effect
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding bus, car, etc.	
Lying down	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	
Lying with head low	
After sexual intercourse	

Sitting erect	
Standing	
Looking up	
Looking down	
Looking from high places	
Looking from moving object	
Noise	
Sudden noise	
Music	
Light	
Strong smells	
When constipated	
Before urine	
During urine	
After urine	
Before menses	
During menses	
After menses	
After sweating	
When fasting	
After eating	
Before important engagement	

Dust	
Smoke	
Touch	
Pressure	
Massage	
Tight clothes	
Before sleep	
During sleep	
After sleep	
After afternoon nap	
Loss of sleep	
Before stools	
During stools	
After stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	
Passing gas	

Before exams	
When angry	
When worried	
When sad	
After weeping	
Receiving consolation or sympathy	
In a crowd	
When thinking of illness	
Full moon, New moon	
In a closed room	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Biting or chewing	
Blowing nose	
When alone	
In company	
Physical exertion	
Belching	

After hair cut	
Combing hair	
Brushing teeth	
Opening mouth	
Moonlight	
Smoking	
Arms hanging down	
Raising the arms	
Near the sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Over-eating	
Working in water	
Fanning	

If more space is needed to describe the effects of a factor, write here:

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper care it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus provide care to the whole.

In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also, such a remedy will help improve your mental make-up.

Answer freely. Answer frankly. Answer completely.

We will not judge you or share your information with others.

Do not write in this column

About what matters are you **anxious**?

When have you had situations of **panic**? When?

Are you **fearful** of anything such as animals, people, being alone, darkness, thunder, the future, etc.

Of what are you **doubtful** or **suspicious**?

What are you **jealous** about? Of whom? From what symptoms do you suffer when jealous?

In which matters are you **impatient**? **Hurried**?

How long do you **remember hurts** caused to you by others?

How much **revengeful** are you?

What are you **proud** of? Does your pride get hurt easily?

Are you **depressed**, brooding, etc.?

Do you ever become **suicidal**? When? If so, in what manner do you contemplate to end your life? Even then, are you afraid of dying?

When are you **cheerful**?

Are you **sexually-minded**?

Any **unwanted thoughts** any time? What are they?

Have you any **imaginary sensations or fears**?

Do you **hear voices**, or that you are called, or anything else in this like that keeps on occurring in your mind unduly?

Do you **weep** easily? What makes your weep? How do you feel after weeping?

Are you **deeply moved** by sad stories or TV shows?

Are you easily **irritated**? What makes your angry?

What **bodily symptoms** do you develop when angry? E.g. trembling, sweating, etc.

Do you like **company** or like to be alone?

How seriously are you affected by **disorder and uncleanliness** round your surroundings?

What are the greatest **griefs** that you have gone through in your life?

What are the greatest **joys** you have had in your life?

What **activities** or hobbies do you like deeply?

What do you do for **fun** or **free time**?

Are there any **matters** which you deeply dislike?

In your opinion, which **aspects of your mind and moods** are not agreeable with you? In spite of your awareness and maturity, are you unable to change these aspects?

Give a clear-cut picture of your **situation in life**.

How does the **future** look to you?

When your mind is quiet or not distracted, what **thoughts** come to your mind?

Are you **worried or unhappy** over any personal, domestic, economic, social or any other condition? If so, describe in detail.

If asked for 3 **desires or wishes** in life, what would you ask for?

SLEEP & DREAMS

Do you have difficulty falling asleep or staying asleep? Describe.

Describe your posture in sleep: on the back, side, abdomen, etc.

Are you able to sleep in any position? In what position can't you sleep?

During sleep, do you (circle all that apply): Snore Grind teeth Dribble saliva Sweat Walk
Keep eyes or mouth open Talk Moan Weep Become restless Startle easily
Wake with a jerk

Describe if anything else is unusual about your sleep.

How much of your body do you cover? Do you have to uncover any parts?

Circle types of dreams that you have

Animals Cats – Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Traveling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death Dead bodies Dead people Part of body Suicide
Being hungry Being thirsty Drinking Eating	Fire Lightening Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work
Vomiting Passing Stool Urinating Blood/Bleeding Excrements	Romantic Sexual pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure Exams Unsuccessful efforts Missing Train Being unprepared
Grief Weeping Vexations Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By Whom? - For what?	If any other, specify in this space:	
Of people Children Parties Feasts Marriage	Of events - Remote - Recent - Future - Prophetic	Physical exertion Mental exertion Fatigue Colored Multi-colored		

FOR CHILDREN
OR
YOU AS A CHILD (IN CASE OF ADULT)

Please mark once (x) if the child or you as a child had any of the following qualities. Mark twice (xx) if they are more intense.

	Mark Here		**Mark Here**
Obstinacy		Unusual Fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like:--	
Hyperactivity		- Biting nails	
Destructiveness		- Thumb sucking	
Courage		Picking and playing with:-	
Possessiveness		- mother's body parts	
Competition, winning spirit		- shawls, handkerchiefs	
Sibling jealousy		- anything else	
Any special skills		Religious, spiritual	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness, indolence	
Telling lies		Sensitive, emotional	

Please describe any other aspect you feel are striking about the child or your childhood.

Please write in detail if the mother suffered from any emotional or physical stress during pregnancy. Also describe any dreams she had during pregnancy (that she might remember).

Describe one incident from the child's life (or your childhood) when he/she was very upset.

HOW TO DESCRIBE YOUR COMPLAINTS

In homeopathy, remedy selection is based on precise details of various symptoms from which you suffer. To tell a homeopath "I have a headache" would not be enough. If you inform him "I have a headache with sharp, shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly, and much worse when rising, walking about or when the head becomes cool," then you have given all the information required to make a good remedy selection. ***The success of the remedy selection depends, largely, on how detailed is your description of your symptoms.***

Therefore, we require the following details about your symptoms:

LOCATION: Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on the next page to indicate location.

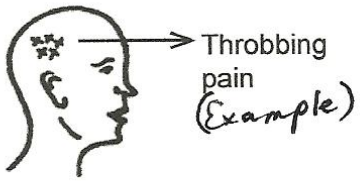
SENSATION: Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart is grasped by an iron hand or you may have pain which is cutting, burning, jerking, pressing. Express the sensation or pain as you feel it.

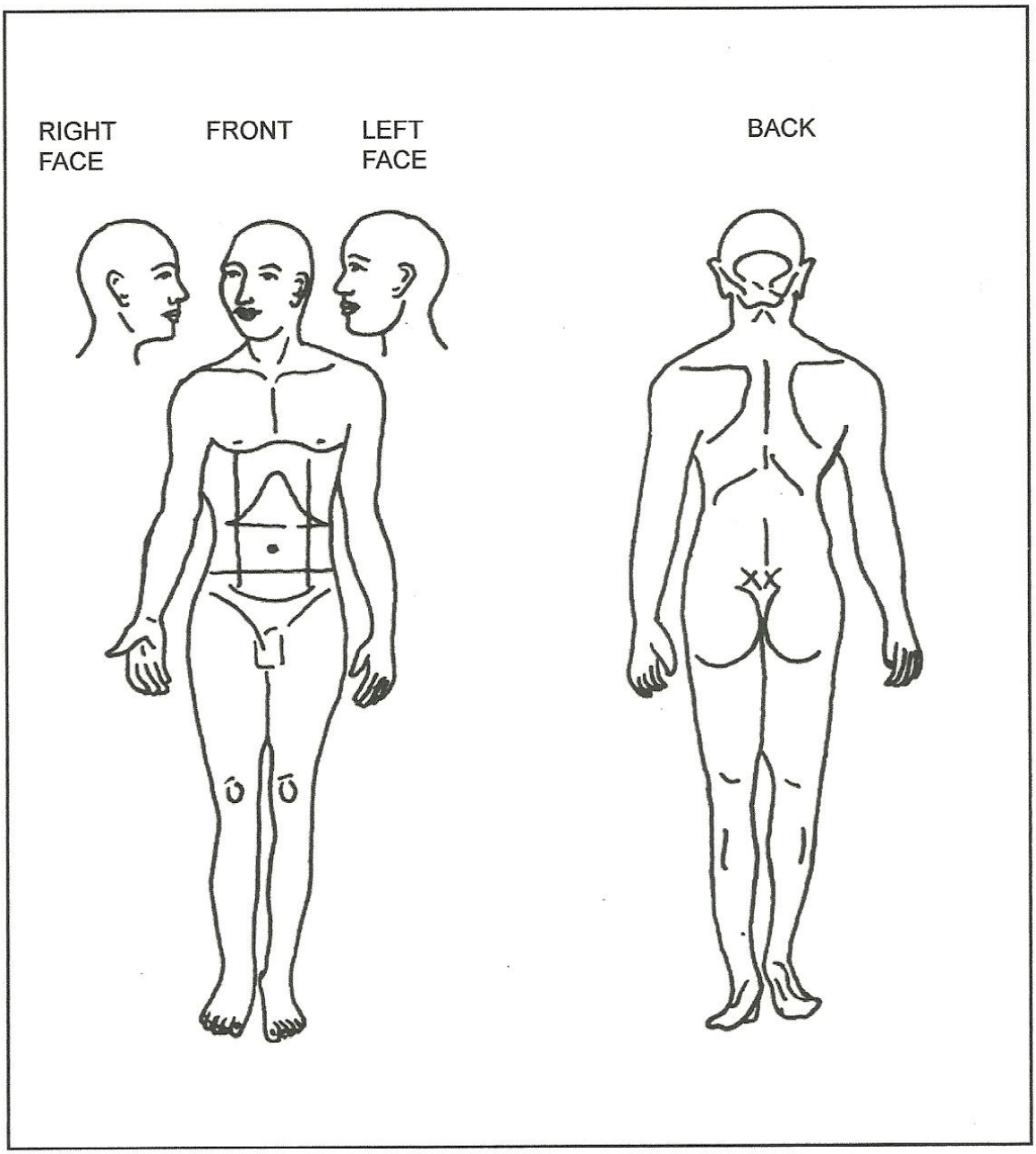
WHAT MAKES YOU BETTER OR WORSE: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors was given earlier. Please refer to them when describing each of your troubles and indicate which factors make the complaints better or worse.

DISCHARGES: You may have a discharge from a wound, eruption in the skin, lungs, eyes, nose, ears, etc. Please describe your discharge under the following aspects:

- The quantity and the time or condition under which the quantity varies; i.e. when is it better or worse, increase or decrease, change color or consistency?
- The consistency: is it thick or thin, stringy or clotted, etc.? Is it like jelly, white of an egg, like water, sticking, forming a scab, etc.?
- What is the color?
- The odor; what does it remind you of?
- Does it make the parts sore? In what way?

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





In the following pages, please describe each of your complaints in detail in the manner described 2 pages ago.

Complaint Number	Where is the trouble?	What EXACTLY do you feel or have there?	What are the factors that make this trouble BETTER or WORSE?
Example	Right side of head	I feel throbbing pain as if my head is being banged on like a drum.	**Better from** lying down and applying heat. **Worse from** thinking and light.

Complaint Number	Where is the trouble?	What EXACTLY do you feel or have there?	What are the factors that make this trouble BETTER or WORSE?

KEEPING YOU HEALTHY IN THE FUTURE

Your Habits:

Your habits	How much NOW	How much in the PAST
Smoking/Chewing tobacco		
Alcohol		
Sleeping pills		
Recreational drugs		
Caffeinated Drinks		
Artificial Sweetener use		

Are there any habits that cause you concern?_____

How much water do you typically drink each day (in "glasses" or "bottles"):_____
Do you primarily drink ( ) bottled water ( ) tap water ( ) home-filtered water

How often do you go on vacation?_____

For women: how often do you wear a bra? ( ) daily ( ) work days only ( ) rarely ( ) never
How many hours/day on average do you wear a bra? ( ) less than 8 ( ) 8-12 ( ) 13-23 ( ) 24
Do you wear an underwire bra? ( ) Yes ( ) No Metal or plastic underwire?_____

How many days per week, on average, do you get at least 20 minutes of sunshine (without sunscreen)? _____

How do you express your creativity?

Do you have people in your life with whom you can confide in all things? ( ) Yes ( ) No

How many times per week do you engage in exercise of at least 30 minutes? _____ x week
( ) Weekend Warrior
What type of exercising do you do?

How do you feel about exercising?

Office Policies

Privacy

No information obtained by this office or its personnel, whether via the telephone, Skype, email or in person will be discussed with another person, family member, or health practitioner without your signed consent, unless the information provided shows intent to harm yourself or others.

Safety/Health Promotion

A client's safety and health are the underlying focuses of all sessions, whether in person or via the telephone, Skype or email. If Dr. Ronda Behnke feels your situation requires immediate medical attention, you will be advised of this and directed to your MD or emergency center; we do not provide emergency medical care.

If you are doing something that Dr. Ronda deems is unsafe or not health-promoting, you will be advised of this. If you choose to continue your actions (such as: take a supplement that you have been advised not to take for safety reasons or taking more than the recommended doses of your homeopathic remedy), Dr. Ronda may not continue to provide care for you.

If Dr. Ronda believes you are harming or will bring harm to yourself or others, she will contact the appropriate emergency intervention or rescue personnel and report the issue. We will work with the emergency intervention personnel completely to ensure your or another's safety, including disclosing your personal details in your file.

Cancellation/No-Show Policy

If you need to cancel or change your appointment time, you need to do that within 2 HCA business days (Monday through Thursday) of your appointment time. You can call and leave a message on the voicemail at **920-558-9806** to do this. You will be called to confirm the receipt of the message shortly after receiving it. If you do not hear back from us within a few hours of leaving the message, call and leave another message. It is your job to ensure your message is received. If your appointment is for a Monday, you need to call by that time on Wednesday (ex: if your appointment is for 11 a.m. on Monday, you need to call by 11 a.m. on Wednesday). **NO EMAILS OR TEXT MESSAGES.** It is also your responsibility to know the correct time of your appointment—if you have any doubt about your scheduled time, you need to call to confirm.

Office Hours

Office hours are Monday through Thursday 9 a.m. – 12 noon and 1 p.m. – 4 p.m. When Dr. Ronda is in session, she does not answer the phone, so please leave a detailed message. Be sure to make your information clear and provide a return phone number.

Coming to Office without Appointment

No one is to come to the office without an appointment. Anyone coming to the office without an appointment will not be seen; in addition, Dr. Ronda will NOT continue to provide consulting for you. **This is a strict policy**. All remedies are mailed if they are not given at the in-person evaluation; if you feel you cannot wait for your remedy, you can contact a local health-food store to see if they carry it.

Forms

A completed Case Record Form is required at the first evaluation. They can be filled out and brought to the appointment; however, if you have a Skype or Phone evaluation, the forms need to be emailed or mailed to us 7 days prior to your scheduled appointment (they cannot be dropped off). If forms are not filled out for your first evaluation, Dr. Ronda will not make recommendations until she receives the completed forms.

Phone Calls & Emails

Phone calls and emails made after business hours will be handled the following business day. Phone calls and emails received during business hours will be returned as time allows throughout the day, or at the end of the day after seeing clients. Note:

1. **For any emergency, call 9-1-1 or your local emergency number.** You will NOT be evaluated if Dr. Ronda feels your situation requires immediate medical attention.
2. Messages about cancellation or changing appointment times can be left on the voicemail at 920-558-9806 (see Cancellation/No Show Policy); **NO EMAILS OR TEXT MESSAGES**.
3. When leaving a message, tell what the phone call is about. Messages left **without** a reason for the call (such as: "This is John Doe at 123-1234") **will not** be returned.
4. Any questions about your previous consultation will be discussed the same business day, if at all possible.
5. Any inquiries about supplements outside the recommendations from the previous consultation will be handled during your next follow-up evaluation.
6. If you call or email to request a consultation with another practitioner, such as emotional counseling, a "report" will be sent at Dr. Ronda's earliest convenience. It will be your responsibility to contact the referred practitioner(s).

Payments and Charges

1. Payments accepted are cash, checks, major credit cards or via PayPal. Credit cards are accepted for in-office patients only; not for over-the-phone orders or such.
2. Charges for cancellation or changes of appointment with less than 1 business days' notice, or a missed appointment will be 100% of the office visit fee; if between 1 and 2 business days then the charge will be 50% of the office visit fee. There is no charged fee if the change or cancellation is made for more than 2 business days in advance.
3. A $35 charge plus bank fees will be applied to NSF checks.

Office visits begin at the time of the scheduled appointment.

If you are late, you will still be charged according to the time for which your appointment was scheduled to begin. If you arrive or call too late before the next scheduled appointment, you will not be evaluated and you will be charged for the appointment. If your appointment goes over the allotted time, additional fees will apply.