Name: Address:	DOB:
Phone: Email: Occupation:	
Reason for Requesting Homeopat	hic Treatment?
	ments you are currently taking (this includes birth ations please indicate if birth control or steroids
Have you ever had an injury to the	e head, spine, or coccyx (tailbone)?
Have you ever had a root canal or age or year if known)	tooth extraction? (Include the tooth number and
Any past experience with homeop	athv?

Today's Date:

Benchmark measurements

1. Choose one or two symptoms which bother you the most. Now consider how bad each symptom is and score it by circling your chosen number.

0 being as good as it could be and 10 being as bad as it could be

Symptom 1 0 1 2 3 4 5 6 7 8 9 10 Write symptom here:

How long have you had Symptom 1, either all the time or on and off? (circle one) 0-4 weeks 4-12 weeks 3 months-1year 1-5 years over 5 years

Symptom 2 0 1 2 3 4 5 6 7 8 9 10 Write symptom here:

How long have you had Symptom 2, either all the time or on and off? (circle one) 0-4 weeks 4-12 weeks 3 months-1year 1-5 years over 5 years

2. Choose an activity (physical, social, or mental) that is important to you and that your problem makes it difficult or prevents you doing. Score how bad it is

0 being as good as it could be and 10 being as bad as it could be

Activity 0 1 2 3 4 5 6 7 8 9 10 Write activity here:

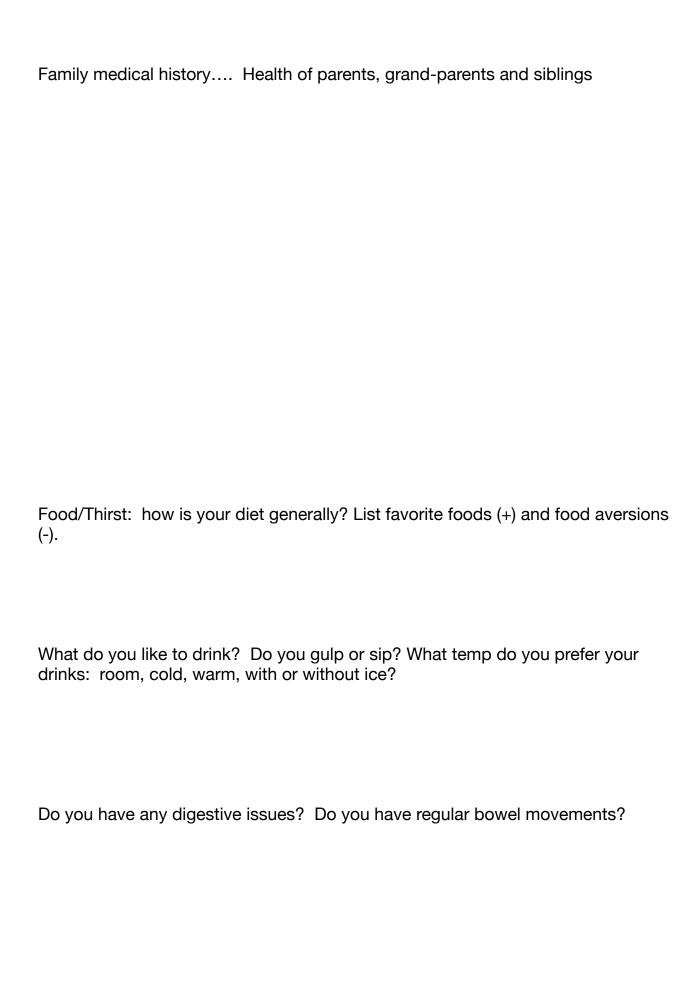
3. How would you rate your general feeling of wellbeing?

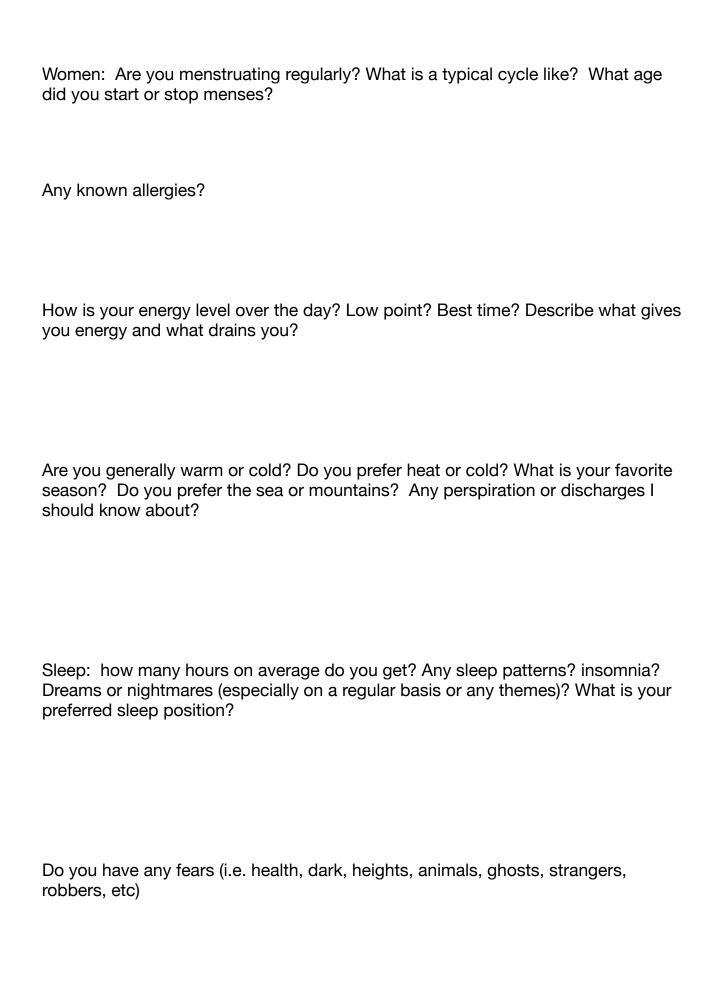
0 being as good as it could be and 10 being as bad as it could be

General Wellbeing 0 1 2 3 4 5 6 7 8 9 10

TIMELINE

YEAR	AGE	LIFE EVENTS	PHYSICALS	MENTAL/ EMOTIONAL	TREATMENT
put the year or your age for the corresp onding event	put the year or your age for the corresp onding event	Include moves, marriage, separation, divorce, any event that had a significance in your life	Include all illnesses, injuries, surgeries, pregnancies, births	Include loss of loved ones or major relationships, stressful situations, difficult relationships	How the items in the previous columns were treated, including medications or alternative treatments, as well as vaccines





What is your libido like?
What do you enjoy doing? (i.e. How do you fill your free time including hobbies)
On a scale of 1 to 10 with 1 being messy and 10 being tidy, how would you rate yourself?
What kinds of things make you angry? What do you do when you are angry?
How would your family or friends describe you?
Anything else you think I should know?