Name: DOB:
Address:

Phone:
Email:
Occupation:

Reason for Requesting Homeopathic Treatment?

List medications, vitamins, supplements you are currently taking (this includes birth control and other long term medications.. please indicate if birth control or steroids have been used in the past)

Have you ever had an injury to the head, spine, or coccyx (tailbone)?

Have you ever had a root canal or tooth extraction? (Include the tooth number and age or year if known)

Any past experience with homeopathy?

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 corresponding event	put the year or your age for the corresponding 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

Family medical history…. Health of parents, grand-parents and siblings

Food/Thirst: how is your diet generally? List favorite foods (+) and food aversions (-).

What do you like to drink? Do you gulp or sip? What temp do you prefer your drinks: room, cold, warm, with or without ice?

Do you have any digestive issues? Do you have regular bowel movements?

Women: Are you menstruating regularly? What is a typical cycle like? What age did you start or stop menses?

Any known allergies?

How is your energy level over the day? Low point? Best time? Describe what gives you energy and what drains you?

Are you generally warm or cold? Do you prefer heat or cold? What is your favorite season? Do you prefer the sea or mountains? Any perspiration or discharges I should know about?

Sleep: how many hours on average do you get? Any sleep patterns? insomnia? Dreams or nightmares (especially on a regular basis or any themes)? What is your preferred sleep position?

Do you have any fears (i.e. health, dark, heights, animals, ghosts, strangers, robbers, etc)

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?