Gwendolyn Burnside, CHE Student
(843) 897-0182
gwen@lowcountryhopeandhealing.com
www.lowcountryhopeandhealing.com

Name: _____ Birth Date: _____

Address: _____

Email Address: _____ Phone Number: _____

Preferred Method of Contact: ☐ Text ☐ Phone ☐ Email Gender: ☐ Male ☐ Female

Emergency Contact: _____ Emergency Contact Phone: _____

Relationship Status: _____

Number of Children: _____ Number of Pregnancies: _____

Family Physician: _____

Family Physician Phone: _____

Occupation: _____

Employer: _____

How did you hear about Lowcountry Hope and Healing? _____

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

Complaint:	Since:	Causes:

WHICH MEDICATIONS ARE YOU CURRENTLY TAKING?

Medications for What Condition?	Since:	Reason:

WHICH NUTRITIONAL SUPPLEMENTS ARE YOU CURRENTLY TAKING?

Supplements for What Condition?	Since:	Reason:

WHAT OTHER TREATMENTS OR THERAPIES ARE YOU CURRENTLY FOLLOWING?

Treatment for What Condition?	Since:	Reason:

WHICH OPERATIONS HAVE YOU HAD?

Operation:	Date:	Complications:

HAVE YOU HAD ANY HEALTH PROBLEMS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL SINCE? WHICH ONES AND WHEN?

RECENT WEIGHT LOSS? ☐ Yes ☐ No HOW MANY POUNDS? _____

RECENT WEIGHT GAIN? ☐ Yes ☐ No HOW MANY POUNDS? _____

TOBACCO USE? ☐ Yes ☐ No HOW OFTEN? _____

ALCOHOL USE? ☐ Yes ☐ No HOW OFTEN? _____

DRUG USE? ☐ Yes ☐ No WHICH AND HOW OFTEN? _____

COFFEE USE? ☐ Yes ☐ No HOW OFTEN? _____

EXERCISE REGULARLY? ☐ Yes ☐ No TYPE & FREQUENCY? _____

PETS? ☐ Yes ☐ No TYPE? _____

Significant childhood illnesses: _____

Significant Injuries: _____

Do you have any allergies? If so, list them:

_____

_____

DO YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

- ☐ Abscesses
- ☐ Addiction (any)
- ☐ ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Cold Sores
- ☐ COVID
- ☐ Croup
- ☐ Diabetes
- ☐ Dyslexia
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Frequent Colds
- ☐ Gallstones/Colic
- ☐ Genital Herpes
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Gum Disease
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Measles
- ☐ Mental Illness
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Neurological Disorder
- ☐ Parasites
- ☐ Pelvic Inflammatory Disease
- ☐ Peritonitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Sexual Abuse
- ☐ Sinusitis
- ☐ Skin Disease/Disorder
- ☐ Strep Throat
- ☐ Stroke
- ☐ Sunstroke
- ☐ Syphilis
- ☐ Tickborne Illness
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Venereal Warts or HPV
- ☐ Whooping Cough
- ☐ Worms
- ☐ Yellow Fever
- ☐ Other(s): _____

CAN YOU TRACE THE ORIGIN OF ANY PRESENT CONDITION TO ANY PARTICULAR CIRCUMSTANCE? (e.g. accident, illness, grief, mental upset, etc.)

_____

_____

_____

ANY SERIOUS SHOCK, GRIEF, DISAPPOINTMENT, FRIGHT, DEPRESSION, ETC.?

_____

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING VACCINATIONS?

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Flu ☐ COVID ☐ Other: _____

Any adverse reactions?

_____

INDICATE WHICH OF THE FOLLOWING AILMENTS HAVE AFFECTED YOUR RELATIVES:						
Alcoholism Allergies Arthritis	Asthma Cancer Depression	Diabetes Epilepsy Gonorrhea	Gout Hay Fever Heart Disease	Mental Illness Paralysis Pneumonia	Skin Disease Syphilis Tuberculosis	Others (Please List):

RELATIVE	AGE (if alive)	AGE (at death)	AILMENTS
Mother			
Father			
Brother(s)			
Sister (s)			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE? ☐ Yes ☐ No

Practitioner Name: For What?

When? Remedies:

Remedies that helped:

DO YOU HAVE A CHURCH COMMUNITY OR SPIRTUAL SUPPORT SYSTEM? ☐ Yes ☐ No

Notes:

ANYTHING ELSE YOU THINK I SHOULD KNOW ABOUT?

Modalities Questionnaire

GENERAL MODALITIES

Factor	Better	Worse
Heat (warm room, hot packs)	☐	☐
Cold (cold air, cold water)	☐	☐
Damp weather	☐	☐
Dry weather	☐	☐
Storms/weather changes	☐	☐
Sun/sun exposure	☐	☐
Fresh air	☐	☐
Open air (windows open)	☐	☐
Drafts/moving air	☐	☐
Rest	☐	☐

Factor	Better	Worse
Motion/walking	☐	☐
Lying down	☐	☐
Lying on painful side	☐	☐
Lying on opposite side	☐	☐
Sitting upright	☐	☐
Standing	☐	☐
Bending over	☐	☐
Touch/pressure	☐	☐
Massage	☐	☐
Rubbing the area	☐	☐
Tight clothes	☐	☐

Factor	Better	Worse
Time of day – Morning	☐	☐
Time of day – Afternoon	☐	☐
Time of day – Evening	☐	☐
Time of day – Night	☐	☐
After eating	☐	☐
When hungry/empty stomach	☐	☐
After drinking	☐	☐
After sleep/naps	☐	☐
While sleeping	☐	☐
After exertion	☐	☐
Before a storm	☐	☐

EMOTIONAL MODALITIES

Factor	Better	Worse
After crying	☐	☐
When alone	☐	☐
In company	☐	☐

Factor	Better	Worse
After expressing anger	☐	☐
During stress or pressure	☐	☐

Factor	Better	Worse
Anticipation/anxiety	☐	☐
Consolation/comfort	☐	☐

SENSORY MODALITIES

Factor	Better	Worse
Noise/sound	☐	☐
Music	☐	☐

Factor	Better	Worse
Light/bright lights	☐	☐
Odors/smells	☐	☐

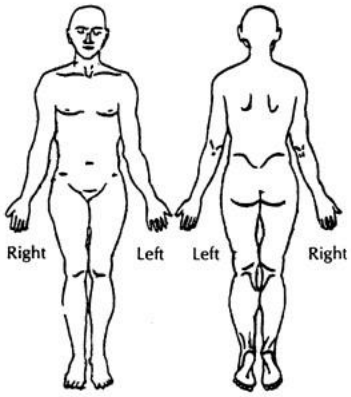
Factor	Better	Worse
Touch	☐	☐
Vibration /jarring	☐	☐

Modalities Questionnaire (continued)

Reporting Symptoms: Determining the proper homeopathic remedy involves investigating and evaluating all the subjective and objective symptoms you are experiencing in your physical symptoms, individual life circumstances, and environment. In order to develop an accurate picture of your circumstances and make our time spent in consultation most effective, please consider the following requests for information as in-depth and accurately as possible. If you have any questions, feel free to contact me.

1. How are you affected by temperature?
2. What parts of your body, if any, get especially hot or cold at certain times or under certain circumstances?
3. How are you affected by the various seasons of the year?
4. How are you affected by different types of weather or climate?
5. How are you affected by open air, drafts, or stuffy rooms?
6. What times of the day do your symptoms tend to be worse or better?
7. How do you prefer your clothing to fit?
8. How are you affected by noises, odors, and light?
9. How is your sleep? How refreshed do you feel upon waking?
10. What position do you tend to sleep in?
11. What sorts of things, if anything, do you do in your sleep (talk, laugh, cry, walk, grind your teeth, dream heavily, etc.)?
12. What dreams have you had consistently? Can you think of a recent dream? A dream from childhood?
13. What fears do you have?
14. Please describe how your body tends to perspire?
15. What foods do you crave or avoid?
16. What foods cause symptoms?
17. How much liquid do you drink in a day and what kind?

Modalities Questionnaire (continued)



Indicate on the image to the left where you are having pain and indicate the intensity of that pain from 1-10; ten being the worst you have ever had.

FOR MEN:

1) Do you experience frequent urination at night?
2) Do you experience a split in your urine flow?
3) Do you experience problems with erectile dysfunction
4) Do you experience any skin irritation or itching in the genital area?

FOR WOMEN:

1) At what age did you have your first menstrual period?
2) What symptoms did you have at that time, if any?
3) How many days usually pass from the start of one menses until the start of the next one?
4) How heavy is the flow and how long does the flow last?
5) What is the color and consistency of the flow?
6) What symptoms do you have *during* your flow, if any?
7) What symptoms do you have *before* or *after* your flow, if any?
8) What type of birth control do you use, if any?
9) If you have ever used chemical birth control, when did you use it, for how long, and did you notice any side effects?
10) Have you had a hysterectomy or tubal ligation? When and what symptoms lead up to this?
11) If you are no longer menstruating, how long ago was your last menses, and did you have any problems during the menopause transition?

Consent & Disclosure Addendum for Homeopathic Services

This document serves as both a disclosure and a client acknowledgment of services provided under South Carolina Code § 40-30-10.

Practitioner: Gwendolyn Burnside
Student Homeopath – Under Supervision
Centre for Homeopathic Education (London, UK)
Practice Name: Lowcountry Hope and Healing, LLC
Location: South Carolina (USA)

Important Disclosure – Please Read Carefully

1. Student Practitioner Status

I am currently a student enrolled at the Centre for Homeopathic Education (London, UK). All consultations are part of my formal education and are conducted under the supervision of a qualified homeopath. This supervision includes case review and guidance to support both practitioner learning and client care.

2. Unlicensed Practice Notice (as required under South Carolina law)

Under South Carolina Code § 40-30-10, I am allowed to offer complementary and alternative health care services as an unlicensed practitioner, provided that I disclose that I am not a licensed medical doctor or other licensed health care provider. Homeopathy is not a licensed health care profession in South Carolina and is offered solely for educational and wellness purposes.

3. Description of Services

Homeopathy involves individualized case-taking and the selection of a homeopathic remedy based on the principle of "like cures like." Remedies are highly diluted natural substances designed to stimulate the body's natural healing ability. These services are not intended to diagnose, treat, or cure any medical condition.

4. Limitations of Services

Homeopathic consultations are not a substitute for medical diagnosis or treatment. I do not perform physical exams, prescribe medications, or recommend stopping any medical treatments or medications prescribed by licensed medical professionals.

5. Voluntary Participation and Client Responsibility

Your participation is voluntary. You are encouraged to ask questions at any time. You remain responsible for your health decisions and are encouraged to seek care from a licensed healthcare provider for any medical concerns, diagnoses, or emergencies.

6. Privacy and Confidentiality

All personal health information is treated as confidential and will only be shared with my supervisor(s) or educational institution as required for educational review, unless you authorize otherwise or if required by law.

7. Audio Recording

With your permission, consultations may be recorded for educational purposes. You may withdraw this consent at any time.

8. Potential Risks

While homeopathy is generally safe, some individuals may experience a temporary worsening of symptoms (commonly referred to as a "healing response" or "aggravation").

9. Fee Schedule

I understand that I am financially responsible for all charges to me. While Gwen Burnside is a student, there is a discounted rate charged that is used to cover supervision fees. (Rates are subject to change.) Please read my terms of service carefully as it lays out my fee schedule and cancellation/rescheduling policy.

Client Acknowledgement and Consent

By signing below, I acknowledge that I have read and understood this disclosure. I understand the nature of homeopathic services being offered and that they are provided by a student practitioner under supervision. I give my voluntary consent to participate in the homeopathic consultation process.

Please check each box to indicate your consent:

☐ I understand the practitioner is a student under supervision.

☐ I understand the practitioner is not a licensed medical provider.

☐ I give permission for my case to be discussed with supervisors.

☐ I consent to receive homeopathic services as described.

☐ I give permission for this consultation to be recorded (if applicable).

☐ I have read and agree to the terms of service: https://lowcountryhopeandhealing.com/terms-of-service

Client Name (printed): _____

Signature: _____

Date: _____

Parent/Guardian Signature (if under 18): _____