Gwendolyn Burnside
(843) 284-6307
gwen@lowcountryhopeandhealing.com
www.lowcountryhopeandhealing.com

Personal Information:

Name: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

Birth Date: _____ Referred By: _____

Primary Care Physician: _____

Specialist Physician(s): _____

_____

Occupation: _____

Name of Partner: _____

Occupation of Partner: _____

Medical History:

Allergies: YES/NO List: _____

Medications: YES/NO

Name: Dosage: Frequency:

1. _____
2. _____
3. _____
4. _____

5. _____

6. _____

Vitamins or Supplements: YES/NO List: _____

Others: _____

Tobacco use: YES/NO Alcohol use: YES/NO

Drug use: YES/NO Coffee use: YES/NO

Do you Exercise Regularly: YES/NO Type: _____

In The Event of An Emergency, Please Notify:

Name: _____ Phone: _____

Number of Children: _____

Members of Household:

Name: Age: Relationship:

_____

_____

_____

_____

_____

Pets: _____

What health problems are you particularly concerned about?

_____

_____

_____

_____

Do you have any significant work or occupational exposure history: YES/NO

To what agents: _____

Significant childhood illnesses: _____

Significant Injuries: _____

<u>Medical Illnesses/ Injuries:</u>

Head: _____ Bladder/ Kidneys: _____

Eyes: _____ Stomach: _____

Ears: _____ Intestines: _____

Nose/ Sinuses: _____ Colon: _____

Mouth: _____ Bones/ Joints: _____

Throat: _____ Genitals: _____

Lungs: _____ Nerves: _____

Heart: _____ Skin: _____

Joints: _____ Blood: _____

Mental/ Emotional: _____ Sexually transmitted: _____

Infectious: _____ Cancer: _____

Nutritional: _____ Endocrine: _____

Other: _____

Hospitalizations: _____

Surgery: _____

Current Emotional Stressors: _____

Significant Current Life Events: _____

Dietary Restrictions: _____

History of Abnormal Laboratory or Radiologic Findings: _____

Significant FAMILY Medical History:

Grandparents: _____

Mother: _____ Father: _____

Siblings: _____

Other: _____

I understand that I am financially responsible for all charges to me.

Signed: _____ Date: _____ /_____ /_____

SYMPTOM QUESTIONNAIRE: Please circle the symptoms you are currently experiencing or have experienced in the past.

MENTAL/EMOTIONAL SYMPTOMS

SPECIFIC FEARS OR PHOBIAS
One or two Many

WORRY A LOT
Generalized Anxiety
State of the World
Family/Children/Husband
Business/Money
Natural Disasters: Earthquake
Thunderstorms
Pollution
Robbers
Violence/Rape
Speaking in Public
Health
Travel Details
Other

FASTIDIOUS/PERFECTIONISTIC
For Order
For Cleanliness
For Time
In Everything

EASILY ANGERED
Hold It In
Let It Out
Scream
Smash/Throw Things
Hit People
Feel Anger in Head, Chest, Stomach

IRRITABLE
Hold It In
With Myself
With Others

IMPATIENT
People are: Stupid
Inefficient
Move Too Slowly
I Hate to Stand in Lines/Traffic

CRITICAL/JUDGMENTAL
Of Myself Others

AMBITIOUS

SADNESS

WEEPING
Easily Often At the Slightest Thing
Not In Front of People

GRIEF
Loss Of Loved One
Of Relationship
Of Business, Possessions
Of Social Position

WISH TO DIE

CONSIDERED/ATTEMPTED SUICIDE
Drugs, Shooting, Drowning, Auto Accident, Jumping, Other

DIFFICULTY MAKING DECISIONS
About Big Things
About Small Things

FORGETFUL

POOR CONCENTRATION

GENERAL SYMPTOMS

COMPLAINTS OCCUR PREDOMINANTLY ON ONE SIDE:
Left Right Upper Lower

TIME OF DAY YOU FEEL THE WORST
Morning Mid-Morning Early Afternoon
Late Afternoon Early Evening Late Evening/Night

TIME OF DAY YOU FEEL THE BEST
Morning Mid-Morning Early Afternoon
Late Afternoon Early Evening Late Evening/Night

DO YOU FEEL: WARMER (or) COLDER THAN MOST PEOPLE?

DO YOU WEAR: MORE (or) LESS CLOTHES THAN MOST PEOPLE?

DO YOU HAVE A STRONG PREFERENCE FOR CERTAIN CLIMATES?
Summer Winter Fall Spring Hot Cold
Damp Humid Foggy Overcast Windy Fresh Air
Drafts

DO YOU HAVE A STRONG DISLIKE FOR CERTAIN CLIMATES:
Summer Winter Fall Spring Hot Cold
Damp Humid Foggy Overcast Windy Fresh Air
Drafts

CURRENT THERAPIES:
Regular Medical Acupuncture Herbs/Vitamins
Chiropractic Osteopathy Massage
Other

HOW MANY HEALTH PRACTITIONERS DO YOU SEE AT THIS TIME?

PLEASE LIST CERTAIN FOODS YOU CRAVE:

PLEASE LIST CERTAIN FOODS YOU CANNOT STAND:

SYMPTOM QUESTIONNAIRE: Please circle the symptoms you are currently experiencing or have experienced in the past.

HISTORY OF HEAD INJURY

FREQUENT OR SEVERE HEADACHES

DIZZY SPELLS/BLACKOUT/FAINTING

BACK PAIN
Neck Mid-Back Low-Back
Sacro-Iliac

CHARACTER OF PAIN
Ache Sore Spasm
Cramp

SCIATICA
Left Right

HISTORY OF BACK INJURY:

MUSCULAR PAINS IN ARMS AND LEGS

JOINT PAIN OR SWELLING

RESTLESSNESS OF HANDS OR FEET

JERKING OF LIMBS

TWITCHING OF MUSCLES

BITING NAILS

FEET GET HOT
Uncover Them at Night

FEET PERSPIRE
Strong Odor

SLEEP IS VERY REFRESHING

WAKE UNREFRESHED

SLEEP PROBLEMS
Worries or Anxious Thoughts
Hard To Fall Asleep
Hard To Stay Asleep
Restlessness
Frequent Waking
Wake Early
Wake At Specific Time: _____

BAD DREAMS

SLEEP POSITION
Sides Left Right Abdomen
Back Knee-Chest

NIGHT SWEATS
Head Neck Chest Back
Feet Other

VISION DISTURBANCES

RECURRENT STYES

HAYFEVER
Itching Eyes
Sneezing
Itching Mouth or Ears
Difficulty Breathing

OTHER ALLERGIES

CHRONIC NASAL OBSTRUCTION

NOSEBLEEDS

FREQUENT 'COLDS'
Just in Head and Nose
Sinusitis
Go Into Sore Throat
End Up in Chest

ASTHMA

ANXIOUS FEELING IN CHEST

CHEST PAINS

RAPID OR SKIPPED HEARTBEAT
Anytime
Especially At Night

ANXIOUS FEELING IN STOMACH

DIGESTIVE PROBLEMS
Discomfort Right After Eating
Awhile After Eating
Unrelated to Eating

ABDOMEN PAIN, DISCOMFORT, BLOATING
Above Naval Below Naval
Relieved By: Belching
Passing Gas
Eating
Fasting

CONSTIPATION
Long-Standing
Related to Menses
Use Laxatives/Enemas, etc.

DIARRHEA

Loose Stools
Frequent Stools
Morning Daytime Night
How Often?

RECTAL PAIN

Relationship to Stool:
Before During After Unrelated

HEMORRHOIDS/FISSURE

WARTS/CONDYLOMATA

MEN ONLY

PROSTATE PROBLEMS

FREQUENT URINATION

Day Night Both

SEXUAL DESIRE

Low Average High
Recent Change?

WARTS/CONDYLOMATA ON GENITALIA

WOMEN ONLY

FREQUENT URINATION

Day Night Both

RECURRENT CYSTITIS

LOOSE URINE WHEN COUGH OR LAUGH

CLOTTING

Large Small

ENDOMETRIOSIS

FIBROID TUMORS/OVARIAN CYSTS

PELVIC INFECTION

Recent In Past

PRE-MENSTRUAL TENSION

Duration in Days?

MENSTRUAL IRREGULARITY

AGE AT FIRST MENSES

MENSTRUAL PROBLEMS

PAINFUL PERIODS

Cramping Stitching Cutting
Twisting Other

WOMEN ONLY (continued)

CLOTTING

Large Small

ENDOMETRIOSIS

FIBROID TUMORS/OVARIAN CYSTS

PELVIC INFECTION

Recent In Past

RECURRENT VAGINITIS

SEXUAL DESIRE

Low Average High
Recent Change

NUMBER OF PREGNANCIES

NUMBER OF BIRTHS

PREMATURE BIRTHS

CAESAREAN

ABORTIONS

GENITAL WARTS/CONDYLOMATA

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 in London. All consultations are part of my formal education and clinical training, and each case is reviewed under professional supervision by a qualified homeopath. Supervision means that a qualified homeopath reviews each case and provides guidance to support both practitioner learning and client care.

_____ By initialing here, I acknowledge that I understand this is a student-led consultation under supervision.

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

I am not a licensed medical doctor, physician, or other licensed healthcare provider in the State of South Carolina. Homeopathy is not licensed by the state, is considered a complementary and alternative health practice, and is not intended to replace medical care from licensed providers.

_____ By initialing here, I acknowledge that I understand the practitioner is not a licensed medical provider and that homeopathy is not a licensed healthcare practice in South Carolina.

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.

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”).

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.

Client Name (printed): _____

Signature: _____

Date: _____

Parent/Guardian Signature (if under 18): _____