

Pre Initial Consultation Questionnaire
Homeopathic Client Information

Note to Client:

In order to determine the best Remedy possible, we require the investigation & evaluation of all the subjective & objective symptoms that you are experiencing in the context of your individual life circumstances & environment.

Therefore, in order to develop an accurate picture of your circumstances (and to make our time spent in consultation most effective) I request that you complete the following information as detailed & accurately as possible.

It is understood that all information is held in strict patient confidentiality.

Client:

Surname First Name

Address City Prov. Postal Code

Home Phone Business Phone E-Mail

Family Doctor:

Surname First Name

Address

Phone Fax E-Mail

Referred by: _____

Chief Complaints:

(Please list in order of importance)

Date of Birth: _____
Sex: _____
Height: _____
Weight: _____
Weight (last year): _____
Hair Color: _____
Eye Color: _____
Marital Status: _____
of Children: _____
Occupation: _____

Intensity: 1= slight discomfort (mild effects, not limiting) 10 = extreme discomfort (severe effects, very limiting)	Frequency: “O” = Occasionally “F” = Frequently “C” = Continual “N” = Never	
INTENSITY	FREQUENCY	
ENERGY / ACTIVITY		SYMPTOMS
		Fatigue, sluggishness
		Apathy, lethargy
		Hyperactivity
		Restlessness
EMOTIONS		SYMPTOMS
		Mood swings
		Anxiety, fear, nervousness
		Anger, irritability, aggressiveness
		Depression
MIND		SYMPTOMS
		Poor memory
		Confusion, poor comprehension
		Poor physical coordination
		Difficulty in making decisions
		Stuttering or stammering
		Slurred speech
		Learning disabilities
HEAD		SYMPTOMS
		Headaches, migraines
		Faintness
		Dizziness
		Insomnia
EYES		SYMPTOMS
		Watery or itchy eyes
		Swollen, reddened / sticky eyelids
		Bags / dark circles under eyes
		Blurred / tunnel vision
EARS		Symptoms
		Itchy ears
		Earaches / ear infections
		Drainage from ear
		Ringing in ears / hearing loss
NOSE		Symptoms
		Stuffy nose sinus problems
		Hay Fever / Allergies
		Sneezing attacks
		Excessive mucus formation

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Mouth/Throat		Symptoms
		Chronic coughing
		Gagging, frequent need to clear
		Sore throat, hoarseness, voice loss
		Swollen/discolored tongue, gums. Lips
		Canker sores
Heart		Symptoms
		Irregular / skipped heartbeat
		Rapid / pounding heartbeat
		Chest Pain
Lungs		Symptoms
		Chest congestion
		Asthma, bronchitis
		Shortness of breath
		Difficulty breathing
Digestion		Symptoms
		Nausea / Vomiting
		Bloating feeling
		Belching
		Heartburn
Elimination		Symptoms
		Diarrhea or Constipation
		Intestinal cramps
		Passing gas
		Frequent urination
		Painful urination
		Blood in waste products
		Mucus in waste products
Joints, Muscle		Symptoms
		Pain / aches in joints
		Arthritis
		Stiffness / movement limitation
		Pain / aches in muscles
		Feeling of weakness / tiredness
Skin		Symptoms
		Acne
		Hives, rashes, dry skin
		Hair loss
		Flushing / hot flashes
		Excessive sweating
Weight		Symptoms
		Binge / compulsive eating or drinking
		Craving certain foods
		Excessive weight /Underweight

Medical History

Immunizations	Yes	No
Diphtheria		
Polio		
Tetanus		
Whooping cough		
Other		
Allergies		
Have you suffered from?	Yes	No
Abortion		
Alcoholism		
Depression		
Drug Abuse		
High / Low Blood Pressure		
Miscarriage		
Pre Menstrual Syndrome		
Sexual Abuse		
Other		
Do you use the following?	Yes	No
Alcohol		
Antacids		
Carbonated beverages		
Coffee		
Distilled water		
Fast foods (regularly)		
Fried Foods		
Laxatives		
Margarine		
No sugar sweeteners		
Salt (without tasting		
Sweets		
Tea		
Tobacco		
Recreational drugs		
Have you suffered from any of the following?	Yes	No
Abscesses		
Anemia		
Arthritis		
Appetite increased (with weight loss)		
Asthma		
Cancer		
Chicken Pox		
Cold Sores		
Diabetes		
Eczema		
Emphysema		
Epilepsy		
Frequent Colds		
Gallstones		
Gout		
Heart disease		
Hepatitis		
HIV		
Influenza		
Kidney Disease		
Leukemia		

Lyme Disease		
Measles		
Mononucleosis		
Multiple Sclerosis		
Mumps		
Parasites		
Pelvic Inflammatory Disease		
Pleurisy		
Pneumonia		
Prostatitis		
Psoriasis		
Rheumatic Fever		
Rubella		
Scarlet Fever		
Sexually Transmitted Disease		
Skin Diseases		
Sinusitis		
Strep Throat		
Tonsillitis		
Tuberculosis		
Venereal Warts		
Warts		
Whooping Cough		
Worms		
Yellow Fever		
Other		

Usage of nutritional supplements? (Please list...vitamins, herbs, etc.)	
What medications have you taken in the past year? Please list current dosage & frequency.	
What other treatments have / are you receiving?	
What surgeries have you had during the course of your life?	
What major injuries have you had during the course of your life?	

Family Health History	Age (at death)	Major Ailments
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal Grandmother		
Maternal Grandfather		
Maternal Uncles / Aunts		
Paternal Grandmother		
Paternal Grandfather		
Paternal Uncles / Aunts		