

Homeopathic Services Health Information Form

This information is confidential and will only be released by your signed consent.

Name _____ Date _____
 Address _____
 Phone (home) _____ (work) _____ (mobile) _____
 (fax) _____ Email address _____
 Birth date _____ Age _____ Height _____ Weight _____ Sex _____
 Legal Status S M D Sep W Living situation _____
 Education(years complete) Elementary ___ High School ___ College ___ Vocational ___ Professional ___
 Social Security # _____ Occupation _____ Retired: Yes No
 Emergency Contact: Name: _____
 Relationship _____ Phone # _____
 If under 18, parents name/address _____
 Referred By _____
 Family Physician _____ Phone _____
 Address _____

Family History

Check if family history is unknown

	Age:	Problems (if dead, cause):	Children (names):	Age:	Problems:
Mother					
Father					
Siblings (names):					

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles):

<p>YES</p> <p><input type="checkbox"/> Alcohol/Drug Problem _____</p> <p><input type="checkbox"/> Allergy/asthma _____</p> <p><input type="checkbox"/> Anemia _____</p> <p><input type="checkbox"/> Arteriosclerosis _____</p> <p><input type="checkbox"/> Arthritis _____</p> <p><input type="checkbox"/> Binge eating/Bulimia _____</p> <p><input type="checkbox"/> Bleeding problem _____</p> <p><input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Epilepsy/seizure _____</p> <p><input type="checkbox"/> Heart disease _____</p> <p><input type="checkbox"/> Skin disease _____</p>	RELATIONSHIP	<p>YES</p> <p><input type="checkbox"/> High blood pressure _____</p> <p><input type="checkbox"/> High Cholesterol _____</p> <p><input type="checkbox"/> Kidney Disease _____</p> <p><input type="checkbox"/> Liver Disease _____</p> <p><input type="checkbox"/> Mental Illness _____</p> <p><input type="checkbox"/> Obesity _____</p> <p><input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> Suicide _____</p> <p><input type="checkbox"/> Thyroid Disease _____</p> <p><input type="checkbox"/> Tuberculosis _____</p> <p><input type="checkbox"/> Ulcer _____</p> <p><input type="checkbox"/> Syphilis _____</p> <p><input type="checkbox"/> Gonorrhea _____</p>	RELATIONSHIP
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Personal History (add extra pages if needed)

Current medications:

(List all prescription and non prescription)

Surgery/Hospitalizations: list all and approximate dates

Allergies – I'm allergic to the following medications:

Lifestyle:

Favorite foods or cravings:

I estimate my use of:

Coffee _____ cups/day Decaf _____ cups/day

Tea _____ cups/day Soda _____ cups/day

I use my salt: none added light moderate heavy

I eat refined sugar yes no

I drink city well spring distilled/filtered water.
_____ glasses per day

How often do you ordinarily eat (anything) in a 24 hour period?

My spiritual life is satisfactory yes no

I am currently involved in a regular spiritual program
 yes no

I participate in an exercise program yes no

I exercise on a regular basis yes no

I think this is enough exercise yes no

I would like to do more exercise yes no

I find my work too demanding boring satisfactory
 very satisfying

My sex life is satisfactory yes no

I sleep well yes no

I worry about money job family life relationships
 other _____

I have been arrested yes no

I have been in the military yes no

I have been the victim of abuse: physical sexual emotional

Vitamin and Mineral Supplements:

(Type and dosage)

Broken bones, traumatic injuries, accidents, concussions

If you have known allergies to foods, chemicals or inhalants
(ie. Pollens, animals, etc...) Please list below:

I often eat seconds Yes No

To control my weight I have used:

diet pills self induced vomiting laxatives

enemas diuretics (water pill) diet/ health

exercise fasting longer than 1 day

other _____

I use beer wine "hard" liquor

I consider myself a non drinker social drinker

heavy drinker alcoholic recovering alcoholic

I am now or have been a smoker: Yes No

How many years have you smoked? _____

When did you quit? _____

What do you smoke now? _____

How much? _____

I use marijuana other drugs _____

I think I need counseling or medical care to control use of:

alcohol tobacco food drugs

I do the following for relaxation/recreation:

Activity: _____ Frequency: _____

My last physical exam was _____

I currently see a psychotherapist or other mental health
professional yes no

I currently see a chiropractor, osteopath, physical therapist
 yes no

I have had a therapeutic massage yes no

Life Changes

In the last 12 months, what changes have occurred in your:

1. Personal Life _____

2. Family Life _____

3. Social Life _____

4. Work Life _____

5. Sex Life _____

Review of Systems

Answer YES if you have had in the last 6 months.

- | YES | YES | YES |
|--|--|--|
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Pain relieved by eating |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Trouble with fried foods |
| <input type="checkbox"/> Chronic depression | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Pain/discomfort when eating |
| <input type="checkbox"/> Trembling episodes | <input type="checkbox"/> Nose bleed | <input type="checkbox"/> Coating on tongue |
| <input type="checkbox"/> Light-headed | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Food craving | <input type="checkbox"/> Change in voice | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Bad teeth | <input type="checkbox"/> Black stool |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Mucus in stool |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Excessive salivation | <input type="checkbox"/> Bloody stool |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clay colored stool |
| <input type="checkbox"/> Chills/fever | <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Change in skin/nails | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Change in wart or mole | <input type="checkbox"/> Bloody/yellow sputum | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Abnormal bleeding/ bruising | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Urination at night |
| <input type="checkbox"/> Unusual hair loss or growth | <input type="checkbox"/> With exertion | <input type="checkbox"/> Foul odor to urine |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> At night | <input type="checkbox"/> Loss of control of urine |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pain/burning urination |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest pain when breathing | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leg cramps at night |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling feet/legs |
| <input type="checkbox"/> Seizure/convulsion | <input type="checkbox"/> Heart skips beats | <input type="checkbox"/> Burning feet |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sore legs/feet |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fast heart beat | <input type="checkbox"/> Color change legs/arms |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pain/fatigue in legs w/exercise |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Cold/hands/feet |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> At rest | MEN |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> With exertion | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> With stress | <input type="checkbox"/> Decreased urine stream |
| <input type="checkbox"/> Loss of any vision | <input type="checkbox"/> With eating | <input type="checkbox"/> Unable to interrupt stream |
| <input type="checkbox"/> Halos around lights | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Excessive tearing/itching | <input type="checkbox"/> Bloating of abdomen | <input type="checkbox"/> Pus or drainage from penis |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Bowel gas | <input type="checkbox"/> Genital swelling/rash |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Belching | <input type="checkbox"/> Problem with sexual function |
| <input type="checkbox"/> Date of last eye exam _____ | <input type="checkbox"/> Change in diet | |

Answer YES if you have had in the last 6 months.

- Muscle pain: Where: _____
- Muscle weakness: Where: _____
- Joint pain: Where: _____
- Joint pain aggravated by motion
- Joint pain relieved by motion
- Swollen joint
- Stiff joints

How do you feel when you wake up in the morning? _____

WOMEN

Answer YES if you have had:

- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Lump in breast
- Self breast exam
Date of last mammogram _____
- Self vaginal exam
- Last menstrual period _____
- Age began menstruation _____
- Usual length of cycle _____
- Usual length of period _____
- Age at menopause _____

List date(s):

- Abnormal pap smear
Date of last pap smear _____
- Infertility
- Problem with sexual function
- Complication of pregnancy
- Used birth control
- Used IUD
type used _____
- Premenstrual Symptoms

List date(s):

Number of pregnancies _____
 Number of live births _____
 No. of abortions/miscarriages _____

PAST HISTORY & WHEN

- Acne /skin problems
- AIDS
- Allergies / Hay fever
- Antibiotics more than 1X/yr
- Anxiety / Depression
- Arteriosclerosis
- Arthritis
- Asthma
- Back pain strain
- Binge eating
- Bladder infection
- Blood problems
- Bronchitis / Pneumonia
- Bulimia
- Cancer
- Cataract
- Chemical Sensitivity
- Chronic Fatigue
- Colds-frequent
- Chicken pox
- Colitis
- Congenital defect
- Counseling / Psychotherapy
- Diabetes

- Ear Infection
- Eczema
- Endometriosis
- Epilepsy
- Epstein Barr
- Fibrocystic breasts
- Fibroids
- Gallbladder problems
- Glasses/Contacts
- Glaucoma
- Gonorrhea /Syphilis
- Gout
- Hearing problems
- Heart problems
- Hemorrhoids
- Hepatitis
- Herpes
- High / Low blood pressure
- Hives
- Hypoglycemia
- Infectious Mono
- Insomnia
- Kidney problems
- Liver disease

- Measles
- Mental Illness
-
- Mumps
- Nervous condition
- Neurological problems
- Nightmares-frequent
- Over / Under weight
- Pelvic infection
- Periodontal disease
- Phlebitis
-
- Prostrate problems
- Rheumatic fever
- Root canal
- Scarlet fever
-
- Sinusitis
- Sleep disorder
- Stoke
- Suicide attempt
- Thyroid problems
- Ulcers
- Vaginitis

Please add anything that you want me to know that has not already been covered (add another sheet if necessary) _____

