

Name:	Age:	Date of Birth:
If Child, Parents Name:		
Address:		
Home Phone: ()	Cell Phone: ()	
Marital Status: S M Part. D W Sep. # of Children: Referred By:		
Occupation:		

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

COMPLAINT	SINCE	CAUSES

LIST MEDICATIONS YOU ARE TAKING NOW:

MEDICATION / FOR	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT OR REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses	Depression	Hay Fever	Measles	Prostatitis	Stroke	
Alcoholism	Diabetes	Heart Disease	Miscarriage	Rheumatic Fever	Syphilis	
Allergies	Emphysema	Hepatitis	Mononucleosis	Rubella	Tonsillitis	
Amnesia	Epilepsy	Herpes	Mumps	Scarlet Fever	Tuberculosis	
Arthritis	Fungus	HPV	Parasites	Sexual Abuse	Typhoid Fever	
Asthma	Gall Stones	Influenza	PID	Skin Disease	Warts	
Cancer	Goiter	Kidney Disease	Peritonitis	Strep Throat	Whooping Cough	
Chicken Pox	Gonorrhea	Leukemia	Pleurisy	Sinusitis	Worms	
Cold Sores	Gout	Malaria	Pneumonia	Sunstroke	Yellow Fever	

Any other major conditions?

Were there any conditions after which you have never been totally well again, or which have been more severe than usual?

What operations have you had and when? Any complications?

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECT

Age of first menses: _____ Age of last menses: _____ Number of pregnancies: _____

What vaccinations have you had?

Any adverse effects?

Have you lost any weight lately? How many pounds?

What exercise do you do and how much?

How much of the following substances are you using?

Tobacco: _____ Alcohol: _____ Coffee: _____ Recreational Drugs: _____

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR AILMENTS HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Diseases
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Father			
Sisters			
Brothers			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			
Other			

Are you currently under the care of another medical provider(s)? For what condition? What has your treatment been?

Have you used homeopathy before? When and for what conditions?

FOR THE FOLLOWING LIST OF FOODS, INDICATE WITH [L] WHICH YOU REALLY LIKE, [D] STRONGLY DISLIKE OR [X] WHICH YOU CANNOT EAT/DRINK.

Alcoholic Drinks	Coffee	Fish	Sour Food	Vinegar
Beer	Cold Drinks	Fruit	Spicy Food	Warm Drinks
Brandy	Cold Food	Meat	Sweets	Warm Food
Cheese	Eggs	Milk	Tea	Wine
Chocolate	Farinaceous (pasta, bread, potatoes)	Salt	Vegetables	Any other food or drinks:

What type of weather do you like and dislike? Why?

What things give you the most pleasure in life?

What things give you the most displeasure? Why?

What fears or phobias do you have?

Do you sleep well? If not, why?

List any characteristic dreams you have now or have had in the past. Include dreams which are/were vivid, recurrent or seemed important to you:

Any additional comments:
