Body Healing Power

Homeopathic Intake Form

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

Name____ Today's date ____________
Last First middle initial

Address____ Birthdate______________

____ Age____Sex___Height_____Weight_______

Phone: Cell: _____________________ Home: __________________ Legal status: S M D Sep W

e-mail address: ____ Occupation ______________

Messages for you may be left at (check all that apply): home____ cell ___ e-mail _____

Emergency Contact name & phone:____

Referred by ____________________________________ Retired: Yes_____ No_____

Family Physician ____ Phone: __________________

Address: ____

FAMILY HISTORY

Check here if family history is unknown ___

	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, siblings, parents, grandparents, aunts, uncles, etc.)

	Relationship
☐ Alcohol/drug problem	________________
☐ Allergy/asthma	________________
☐ Anemia	________________
☐ Atherosclerosis	________________
☐ Arthritis	________________
☐ Binge eating/bulimia	________________
☐ Bleeding problem	________________
☐ Cancer	________________
☐ Diabetes	________________
☐ Epilepsy/seizure	________________
☐ Heart disease	________________
☐ Skin disease	________________
☐ Endocrine/hormone imbalance	________________

	Relationship
☐ High blood pressure	________________
☐ High cholesterol/fat	________________
☐ Kidney disease	________________
☐ Liver disease	________________
☐ Mental illness	________________
☐ Obesity	________________
☐ Stroke	________________
☐ Suicide	________________
☐ Thyroid disease	________________
☐ Tuberculosis	________________
☐ Gastro intestinal disease	________________
☐ Syphilis	________________
☐ Gonorrhea	________________

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgeries and other hospitalizations and approximate dates

____ ______________
____ ______________
____ ______________
____ ______________

Broken bones and/or traumatic injuries (include all car accidents or concussions)

____ ______________
____ ______________
____ ______________

PERSONAL HISTORY

	When
☐ Acne	_______
☐ AIDS	_______
☐ Alcohol problem	_______
☐ Allergies	_______
☐ Anemia	_______
☐ Antibiotics	_______
☐ Anorexia	_______
☐ Anxiety	_______
☐ Arteriosclerosis	_______
☐ Arthritis	_______
☐ Asthma	_______
☐ Back pain/strain	_______
☐ Binge eating	_______
☐ Bladder infection	_______
☐ Blood clots	_______
☐ Breast lump	_______
☐ Bronchitis	_______
☐ Bulimia	_______
☐ Cancer	_______
☐ Cataract	_______
☐ Chemical sensitivity	_______
☐ Chicken pox	_______
☐ Chronic fatigue	_______
☐ Colds, frequent	_______
☐ Colitis	_______
☐ Congenital defect	_______
☐ Counseling	_______
☐ Depression	_______
☐ Diabetes	_______
☐ Ear infection	_______
☐ Eczema	_______
☐ Endometriosis	_______
☐ Epilepsy	_______

	When
☐ Epstein Barr/ infectious mono	_______
☐ Fibrocystic breast	_______
☐ Fibroids	_______
☐ Gallbladder problem	_______
☐ Glaucoma	_______
☐ Gonorrhea	_______
☐ Gout	_______
☐ Hay fever	_______
☐ Hearing problem	_______
☐ Heart attack	_______
☐ Heart failure	_______
☐ Heart problem	_______
☐ Hemorrhoids	_______
☐ Hepatitis	_______
☐ Herpes	_______
☐ Hiatal hernia	_______
☐ High blood pressure	_______
☐ High cholesterol/ triglycerides	_______
☐ Hives	_______
☐ Hypoglycemia	_______
☐ Insomnia	_______
☐ Kidney infection	_______
☐ Kidney stones	_______
☐ Kidney problems	_______
☐ Liver disease	_______
☐ Menstrual problem	_______
☐ Mental illness	_______
☐ Migraine	_______
☐ Nervous condition	_______
☐ Neurologic problem	_______
☐ Overweight (20+lbs)	_______
☐ Panic attacks	_______

	When
☐ Pelvic infection	_______
☐ Peptic ulcer	_______
☐ Periodontal disease	_______
☐ Phlebitis	_______
☐ Pneumonia	_______
☐ Premenstrual tension	_______
☐ Prostate problem	_______
☐ Psychotherapy	_______
☐ Reactions to vaccinations	_______
☐ Rheumatic fever	_______
☐ Root canal	_______
☐ Scarlet fever	_______
☐ Sexually transmitted disease	_______
☐ Sinusitis	_______
☐ Skin problem	_______
☐ Sleep disorder	_______
☐ Stroke	_______
☐ Suicide attempt	_______
☐ Syphilis	_______
☐ Taken steroids (cortisone/prednisone, etc)	_______
☐ Thyroid problem	_______
☐ Tonsillitis	_______
☐ Tooth problems	_______
☐ Tuberculosis	_______
☐ Urine problem	_______
☐ Vaginitis	_______
☐ Vision problem	_______
☐ Warts	_______
☐ Other problems	_______
☐ _____________	_______

REVIEW OF SYSTEMS

Check the box if you have had these symptoms ***in the last 6 months***

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food craving
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headache
- ☐ Dizziness
- ☐ Balance problem
- ☐ Head injury
- ☐ Seizure/convulsion
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under eyes
- ☐ Date last eye exam ____
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breather

- ☐ Chronic cough
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ …with exertion
- ☐ …at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain or pressure
- ☐ … at rest
- ☐ …with exertion
- ☐ …with stress
- ☐ …with eating
- ☐ … down left arm, neck or back
- ☐ …accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skip beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Joint pain
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficult swallowing
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Canker sores
- ☐ Pain relived by eating
- ☐ Nausea/vomiting
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucous in stool

- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Foul odor to urine
- ☐ Low back pain
- ☐ Loss of control of urine

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

WOMEN

Last menstrual period ____________________

Age began menstruation ____________________

Age at menopause ______________

Number of pregnancies _________

Number of live births __________

Number of abortions/ Miscarriages _________

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD

Usual length of cycle _________

Usual length of period ________

- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

Date of last pap smear __________

PERSONAL HISTORY

Current medications

List all prescriptions and non-prescriptions including doses

____
____
____
____
____
____

Vitamin and mineral supplements

Type and dosage

____
____
____
____
____
____

Food allergies and method of testing

____
____
____

Allergies to medications

____
____
____

Lifestyle

List your favorite foods or cravings
____

I am now or have been a smoker ☐ yes ☐ no How many years have you smoked? _______
How much do/did you smoke? ____________________When did you quit? __________

I estimate my use of: coffee: _____cups/day decaf: _____cups/day
I use: ☐ beer ☐ wine ☐ "hard" liquor. I consider myself a ☐ non-drinker ☐ social drinker
☐heavy drinker ☐ alcoholic ☐ recovering alcoholic.

I use: ☐ marijuana ☐ other drugs ______________________

I have participated in an exercise program. ☐yes☐ no. I exercise on a regular basis ☐yes ☐ no.
_____ times per week/month. I think this is enough ☐yes ☐ no. I would like to do more ☐yes ☐ no

I find my work: ☐ too demanding ☐ boring ☐ satisfactory ☐ very satisfying.
My sex life is satisfactory ☐yes ☐no.
I do the following for relaxation/recreation: ______________________________________
I sleep well ☐ yes ☐ no. I worry about ☐ money ☐ job ☐ family life ☐ relationships ☐ other_________
I currently see a psychotherapist or other mental health professional ☐yes ☐no.
I have been arrested ☐ yes ☐no. I have been in the military service ☐yes ☐no.
I have been a victim of abuse ☐ physical☐ emotional ☐sexual.
My spiritual life is satisfactory ☐yes ☐no. I am involved in a regular spiritual program ☐yes ☐no
My last physical exam was ____________________

Homeopathy treats each individual as a whole. This means subtle things such as dreams, patterns of your symptoms (time of day, periodicity, what makes them worse or better) can be helpful in the analysis of your case. Please take note of these things in the next few days before your appointment. I look forward to working with you. Dawn