Homeopathic Intake Form (part 1)

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Homeopathic consultation is facilitated when there is a complete picture of the individual's mental, emotional and physical states of health. This includes symptoms that affect both physical sensations (what does it feel like), and function (how it impacts you) and what improves or aggravates each symptom. **Please print, fill out this form and bring to your appointment.**

Date: _____
Name _____ Age___ Birth date _____Sex ___
Address_____
City_____ State _____ Zip _____
Phone (home)_____(work)_____ (cell)_____
E-mail _____
Occupation _____Full-time/Part-time _____Retired____
Employed by_____
Education_____
Married ____ Separated _____ Divorced_____ Widowed _____ Single_____

Are you familiar with or have you ever had Homeopathic treatment? If yes, what remedies have you taken and what remedies have helped?

_____
_____

Can you list ten separate words that describe some positive and negative traits in your personality?

In your opinion, what are your most important health problems? List as many as you can in order of importance:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Past Medical History:

When did your complaint/ailment begin? What was happening in your life then?

_____
_____

What do you think causes or has caused your ailment or complaint?

_____
_____
_____

Have you had an experience (traumatic, illness, vaccine or other) that did or still affects you deeply? Explain.

_____
_____
_____

The general state of my health has been:
Excellent____ Good ____Fair ____ Poor ____

What childhood illnesses have you had?

____ Rubella (3 day-measles)	____ Mumps	____ Chickenpox
____ Measles (2 weeks)	____ Whooping Cough	____ Asthma
____ Scarlet Fever	____ Rheumatic Fever	

Others: _____

If you have had any of the following tests or immunizations, place an (X) on the appropriate line and/or give the (approximate) year.

Year	**Tests**	**Year**	**Immunizations**
_____	Chest x-ray	_____	Smallpox
_____	G.I. Series	_____	Tetanus
_____	Colon x-ray (Barium enema)	_____	Polio
_____	Kidney x-ray	_____	Typhoid
_____	Electrocardiogram	_____	Diphtheria
_____	MMR	_____	Flu
_____	Other _____		

Your Health History:

Now	**Past**	**Never**		**Now**	**Past**	**Never**	
____	____	____	Addictions	____	____	____	Diabetes
____	____	____	Alcohol	____	____	____	Drugs
____	____	____	AIDS	____	____	____	Eczema
____	____	____	Allergies	____	____	____	Emphysema
____	____	____	Anemia	____	____	____	Epilepsy
____	____	____	Anorexia	____	____	____	Gout
____	____	____	Asthma	____	____	____	Heart Condition
____	____	____	Bleeding	____	____	____	Hepatitis
____	____	____	Bruising	____	____	____	Herpes
____	____	____	Bulimia	____	____	____	Hypertension
____	____	____	Cancer	____	____	____	Kidney Disease
____	____	____	Colitis	____	____	____	Liver Disease
____	____	____	Convulsions	____	____	____	Mental Disease
____	____	____	Depression	____	____	____	Migraines
____	____	____	Obesity	____	____	____	Pneumonia
____	____	____	Rheumatism	____	____	____	STD
____	____	____	Thyroid	____	____	____	Tuberculosis

Hospitalizations: List as best as you can.

Type of illness/operation	Date:	Where:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Use:

Yes	**Amount**	**Yes**	**Amount**
____ Coffee	_____	_____ Birth Control Pills	_____
____ Cigarettes	_____	_____ Sedatives/Tranquilizers	_____
____ Alcohol	_____	_____ Thyroid	_____
____ Aspirin	_____	_____ Laxatives	_____
____Other Drugs	_____	_____ Cortisone	_____

Yes	**Amount**	**Yes**	**Amount**
____ Electric Blanket	_____	_____ Hormones	_____
____ Herbs/Teas	_____	_____ Vitamins	_____
____ Recreational drugs	_____	_____ Other therapies	_____

Are you allergic to any drugs (penicillin, etc.) Are you allergic to foods or other substances?_____

What happens when you have an "allergy attack" or "sensitivity reaction"?

_____

Family History:

Please list ages, and if deceased, what was the cause and at what age:

Relation	**Living**	**Died**	**Cause**	**Age**
Your mother	_____	_____	_____	_____
Your father	_____	_____	_____	_____
Your brother (s)	_____	_____	_____	_____
	_____	_____	_____	_____
Your sister (s)	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's side				
Your grandfather	_____	_____	_____	_____
Your grandmother	_____	_____	_____	_____
Father's Side				
Your grandfather	_____	_____	_____	_____
Your grandmother	_____	_____	_____	_____

Has any **blood relative** had any of the following?

Yes	No	D.K. (Don't Know)	Yes	No	D.K.
___	___	___ Allergies	___	___	___ Gout
___	___	___ Anemia	___	___	___ Hay Fever
___	___	___ Arthritis	___	___	___ Heart Attack
___	___	___ Asthma	___	___	___ High Blood Pressure
___	___	___ Bleeding	___	___	___ Seizure/Epilepsy
___	___	___ Cancer	___	___	___ Sickle Cell Anemia
___	___	___ Diabetes	___	___	___ Stroke
___	___	___ Depression	___	___	___ Thyroid Trouble
___	___	___ Eczema	___	___	___ Tuberculosis
___	___	___ Glaucoma	___	___	___Venereal Disease

Symptoms: Please mark **1** (mild), **2** (moderate), **3** (severe) if any of the following apply to you NOW or in the PAST.

Skin

Now Past

____ ____ skin: rough, dry, scaly, bumpy, itchy (circle)
____ ____ rashes, warts, moles, cysts (circle)
____ ____ light or dark patches of skin (circle)
____ ____ increased hair growth in unusual places
____ ____ pimples

Now Past

____ ____ color changes in nails
____ ____ hives
____ ____ loss of hair
____ ____ ridges, pits or spots on nails
____ ____ infections, fungal symptoms

Blood, Lymph, Immune

____ ____ Swollen or painful lymph nodes
____ ____ Wounds heal slowly
____ ____ Difficulty stopping bleeding
____ ____ Swollen glands
____ ____ Bruise easily

Endocrine

____ ____ Excessive hair growth
____ ____ Cold hands or feet
____ ____ Weakness
____ ____ Can't stand cold
____ ____ Chronic fatigue
____ ____ Prefer cold weather
____ ____ Unexplained thirst
____ ____ Increased hunger
____ ____ Can't stand heat
____ ____ Profuse sweating

Head

____ ____ Dizziness
____ ____ Severe headaches
____ ____ Seizures/tics/spasms
____ ____ Double vision
____ ____ Fainting spells
____ ____ Injuries

Eyes

____ ____ Infections
____ ____ Blurred vision
____ ____ Sensitive to light
____ ____ Near/far sighted
____ ____ Floaters
____ ____ Injuries

Ears

____ ____ Discharge from ears
____ ____ Pain in ears
____ ____ Hearing trouble
____ ____ Infections
____ ____ Injuries
____ ____ Noises in ears

Nose

____ ____ Nose bleeds
____ ____ Sinus problems
____ ____ Obstruction - difficulty breathing through nose
____ ____ Injury
____ ____ Loss of smell

Mouth

____ ____ Sore mouth or tongue
____ ____ Infections
____ ____ Loss of teeth
____ ____ Bad breath
____ ____ Gum disease
____ ____ Speech difficulties

Throat

____ ____ Persistent hoarseness
____ ____ Difficulty swallowing
____ ____ Loss of voice
____ ____ Pain
____ ____ Infections
____ ____ Swelling

Neck

____ ____ Stiffness
____ ____ Injuries
____ ____ Swelling

Respiratory

Now Past

____ ____ Unexplained fever
____ ____ Chest pain
____ ____ Wheezing
____ ____ Infections
____ ____ Difficulty breathing at night (wakes you up)
____ ____ Night sweats
____ ____ Shortness of breath
____ ____ Daily cough
____ ____ Difficulty breathing

Cardiovascular

____ ____ Chest pain when walking
____ ____ Ankle-swelling
____ ____ Shortness of breath
____ ____ Heart palpitations (fluttering, pressure, skipping, rapid beat)
____ ____Varicose veins
____ ____ Hypertension (HBP)
____ ____ Leg pain (walking)

Digestive System

____ ____ Frequent or severe symptoms
____ ____ Blood in stools
____ ____ Change in bowel movements
____ ____ Heartburn
____ ____ Indigestion
____ ____ Excessive belching
____ ____ Stomach pain
____ ____ Distress from fats or greasy foods
____ ____ Stools yellow, clay-colored, foul odored, has undigested food
____ ____ Bad breath, bad taste in mouth; body odor (including feet)
____ ____ Indigestion after meals (fullness, bloating, sourness, etc.)
____ ____ Heavy, full feeling after eating
____ ____ History of constipation or diarrhea
____ ____ Excessive lower bowel gas
____ ____ Stomach pain occurs 5 or 6 hours after eating
____ ____ History of constipation or diarrhea
____ ____ Indigestion occurs immediately after eating
____ ____ Nervousness, shaky feelings, headaches, relieved by eating
____ ____ Irritable if late for meal, miss meal, or before eating breakfast
____ ____ Sudden, strong craving for sweets or alcohol
____ ____ Wake up at night feeling hungry
____ ____ Overweight
____ ____ Sudden weight loss
____ ____ Infection
____ ____ Sleepy during the day? When? _____
____ ____ Black stools
____ ____ Vomiting blood
____ ____ Anal itching
____ ____ Yellow jaundice
____ ____ Diff. swallowing
____ ____ Loss of appetite
____ ____ Sudden weight gain
____ ____ Injury

How often do you have bowel movements?_____

Do you strain at stool? _____. Have you had a change of appetite? _____Increase / decrease? _____.Of what does your diet consist ? _____

_____

_____

Do you snack?_____. On what? _____

_____

What foods, condiments, or any other substances (i.e. chocolate, ice-cream, mustard, sour, spicy, etc.) do you crave? _____

Are you repelled by, or do you dislike any foods?

_____

Are there any foods that trouble or aggravate or do not agree with you? In what way?

_____

Are you thirsty? ____ For hot drinks _____ For cold drinks_____

Ice in your drinks ____ Do you like to chew ice? ____

Urogenital System

Now Past

____ ____ Frequent urination ____ ____ Painful urination

____ ____ Night urination

____ ____ Trouble starting urine ____ ____ Trouble holding

____ ____ Frequent urging with scant urination

Male Problems

____ ____ Any prostate problems

____ ____ Discharge from penis

____ ____ Difficulty achieving or maintaining an erection

____ ____ Painful erection

____ ____ Difficulty with ejaculation

____ ____ Lumps, swelling or pain in testicles

____ ____ Infection

____ ____ Infertility

____ ____ Injury

Female Problems

____ ____ Discharge from vagina

____ ____ Difficulty feeling sexually aroused

____ ____ No lubrication when aroused

____ ____ Never or seldom have orgasms

____ ____ Sex is painful ____ ____ Pelvic pain

____ ____ Menstrual flow is excessive/absent (circle)

____ ____ Bleeding or spotting between periods

____ ____ Pain before, during/after periods (circle)

____ ____ Infection ____ ____ Infertility

____ ____ Lumps in breast

____ ____ Premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, (circle) other…

Spine and Extremities

____ ____ Joint pain, swelling, stiffness, tingling, numbness

Where? _____

____ ____ Muscle cramps ____ ____ Backaches

____ ____ Burning soles of feet

____ ____ Unusual redness of palms of hands
____ ____ Injuries
____ ____ Other
Have you ever had arthritis? _____
Where _____What kind _____

Nervous System

Now Past

____ ____ Loss of balance ____ ____ Paralysis
____ ____ Lack of strength (seizures, stiffness)
____ ____ Convulsions ____ ____ Numbness
____ ____ Tremor (shaking, involuntary movements, tics, spasms)

General

Are you a warm or chilly person? _____
Are you sensitive to changes in weather? _____ sun _____ drafts _____
wind ___ noise ___ ordered environment _____ other _____
_____
When in bed, if you feel warm, what part of your body would you tend to uncover first? _____. Do you usually dream? _____. Are there specific dreams or recurring themes to your dreams? If so, what?_____
_____

Mental/Emotional

Now Past

____ ____ Restlessness ____ ____ Anxiety
____ ____ Excessive worry ____ ____ Nervousness
____ ____ Memory trouble ____ ____ Trouble concentrating
____ ____ Depression ____ ____ Crying spells
____ ____ Trouble sleeping ____ ____ Frequent nightmares
____ ____ Trouble getting along with people
____ ____ Easily angered ____ ____ Feelings of worthlessness
____ ____ Mood swings ____ ____ Suicidal thoughts
____ ____ Fearful ____ ____ Excess stress
____ ____ Loss of someone dear through death or separation
____ ____ Always put others' interests before mine
____ ____ See things that others don't
____ ____ Hear voices
____ ____ Think others want to hurt you
____ ____ Don't know how to relieve stress
____ ____ Is order important to your surroundings?
____ ____Are you generally late for appointments?
____ ____ Do you tend to leave things undone until the last minute
____ ____ Peculiar sensations? What? _____
Where?_____
How do symptoms of stress show up in you (physically/emotionally)?
_____
_____
What are your triggers for stress_____
_____
_____

How do you alleviate stress?_____
_____
_____

Do you have anything else you have noticed or wish to add?
_____
_____
_____
_____
_____
_____

I understand that a homeopathic remedy, not easily obtained elsewhere may be given free-of - charge with your consultation as well as subsequent follow-up consultations. Should a repeat of the remedy be needed between follow-ups, a $20.00 fee (plus shipping, if necessary) will be charged.

I confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

I understand that a block of time has been set aside for my private appointment, and that a 24- hour notification is required if I must cancel. I understand that a $50 fee will be charged for appointments canceled less than 24 hours in advance.

Homeopathy is considered to be an alternative/preventative system of health care, and is not intended to be a substitute for allopathic or traditional medicine. The therapy and information offered should not be construed by you, the client, to be a medical diagnosis of any disease or injury.

You should consult with your physician for any serious medical condition and request at least two medical opinions for such condition.

I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Signature: _____. Date: _____

If client is under 18 years, parental signature is required.

Homeopathic Intake Form *(Part 2)*

Instructions for Completing This Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may determine which remedy is best suited for you.

All information in this questionnaire is kept confidential.

The questionnaire is designed to be user friendly. You can answer many of the questions by placing a circle around the appropriate number. For example:

Which weather conditions are you most troubled by?
Circling a number closer to the clear end means that you are most troubled by clear weather. Circling a number closer to the cloudy end means that you are troubled by cloudy weather.

Cloudy Clear
12345678910

Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. Circling number “1” means that you are troubled very little while marking “10” means that you are troubled a lot. For example;

Do you worry about any of the following?
Circling closer to “10” means that you worry about your health a lot. Circling closer to “1” means that you do not worry about your health.

12345678910 Health

Some questions ask you to circle the answer you think best fits you. For example:

What are your feelings toward disease?

Optimistic
Doubtful of Recovery
Fearful
Despair of Recovery

Name:_____

Date:_____

The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Wet Dry
1 2 3 4 5 6 7 8 9 10

Damp cold Snow (Dry Cold)
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble?

Winter Spring
Fall Summer

Are you worse being in the:

Mountains At the seashore
1 2 3 4 5 6 7 8 9 10

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

Are you generally chilly or warm?

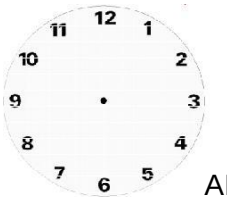
Chilly Warm
1 2 3 4 5 6 7 8 9 10

Which are you generally most sensitive to, warm or cold?

Cold Warm
1 2 3 4 5 6 7 8 9 10

What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?

Worst Best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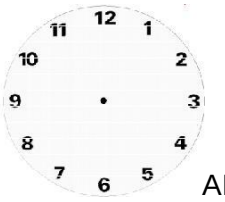
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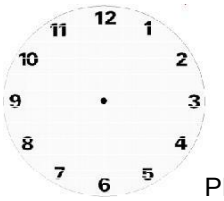
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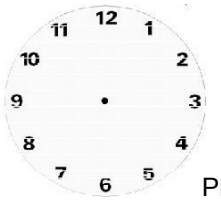
PM

Symptoms during sleep. Circle which you have.

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Nightmares
Recurring Dreams
Sleepwalking

Circle what you prefer. Do you sleep:

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You
With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you have difficulty waking?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you wake unrefreshed?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Food Desires and Aversions:
In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

Tastes:

1 2 3 4 5 6 7 8 9 10	Sweet
1 2 3 4 5 6 7 8 9 10	Sour
1 2 3 4 5 6 7 8 9 10	Salty
1 2 3 4 5 6 7 8 9 10	Bitter
1 2 3 4 5 6 7 8 9 10	Spicy (hot)
1 2 3 4 5 6 7 8 9 10	Smoked
1 2 3 4 5 6 7 8 9 10	Juicy
1 2 3 4 5 6 7 8 9 10	Refreshing
1 2 3 4 5 6 7 8 9 10	Pungent

Foods:

1 2 3 4 5 6 7 8 9 10	Alcohol
1 2 3 4 5 6 7 8 9 10	Apples
1 2 3 4 5 6 7 8 9 10	Bacon
1 2 3 4 5 6 7 8 9 10	Bread alone
1 2 3 4 5 6 7 8 9 10	Bread with butter
1 2 3 4 5 6 7 8 9 10	Butter alone
1 2 3 4 5 6 7 8 9 10	Cheese
1 2 3 4 5 6 7 8 9 10	Chocolate
1 2 3 4 5 6 7 8 9 10	Coffee
1 2 3 4 5 6 7 8 9 10	Pastries
1 2 3 4 5 6 7 8 9 10	Eggs
1 2 3 4 5 6 7 8 9 10	Fat (meat, chicken, pork, etc.)
1 2 3 4 5 6 7 8 9 10	Fish
1 2 3 4 5 6 7 8 9 10	Fruit
1 2 3 4 5 6 7 8 9 10	Fruit (sour)
1 2 3 4 5 6 7 8 9 10	Grain products (pasta, bread, cereal, etc.)
1 2 3 4 5 6 7 8 9 10	Ham
1 2 3 4 5 6 7 8 9 10	Ice
1 2 3 4 5 6 7 8 9 10	Ice cream
1 2 3 4 5 6 7 8 9 10	Indigestible things (chalk, clay, paper, etc.)
1 2 3 4 5 6 7 8 9 10	Lemonade
1 2 3 4 5 6 7 8 9 10	Meat
1 2 3 4 5 6 7 8 9 10	Milk
1 2 3 4 5 6 7 8 9 10	Nut butters
1 2 3 4 5 6 7 8 9 10	Oysters
1 2 3 4 5 6 7 8 9 10	Pickles
1 2 3 4 5 6 7 8 9 10	Vegetables
1 2 3 4 5 6 7 8 9 10	Vinegar

Temperature of food. Which do you prefer?

Warm Food Cold Food
1 2 3 4 5 6 7 8 9 10

Warm Drinks Cold Drinks
1 2 3 4 5 6 7 8 9 10

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

How thirsty are you generally?

Not at all Very
1 2 3 4 5 6 7 8 9 10

Mental and Emotional State:

How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

Do you worry about any of the following? 10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

1 2 3 4 5 6 7 8 9 10 Irresolution (Not being able to decide or stick to a decision)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Frightened Easily Never Afraid
1 2 3 4 5 6 7 8 9 10

Answer as honestly as you can about your personality traits.

Stingy Overly generous
1 2 3 4 5 6 7 8 9 10

Thrifty Extravagant
1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow
1 2 3 4 5 6 7 8 9 10

Messy Particular
1 2 3 4 5 6 7 8 9 10

Calm Restlessness
1 2 3 4 5 6 7 8 9 10

Indolence (Lazy) Always busy
1 2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful Outgoing
1 2 3 4 5 6 7 8 9 10

Anger Mildness
1 2 3 4 5 6 7 8 9 10

Lack of moral sense Guilty
1 2 3 4 5 6 7 8 9 10

No Religious feeling Highly Religious Feeling
1 2 3 4 5 6 7 8 9 10

Obstinate (stubborn) Yielding
1 2 3 4 5 6 7 8 9 10

Heedless/Reckless Cowardice
1 2 3 4 5 6 7 8 9 10

Social/Antisocial. In regard to being with other people or in company?

Aversion Desire for
1 2 3 4 5 6 7 8 9 10

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Grief
Dwells on Past
Inconsolable
Remorse
Guilt

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward disease/condition:

Optimistic
Doubtful of recovery
Discouraged
Fearful
Despair of recovery

Feeling toward life

Love life
Indifferent
Bored
Weary of life
Loathing of life
Desires death
Suicidal thoughts
Suicidal disposition

Feeling toward spouse/lover:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

How much do you have the following symptoms?
10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

1 2 3 4 5 6 7 8 9 10 Mood

Alternating Moods Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

Morose
Sad
Apathy/Indifferent
Excitement
Exhilaration

How do you experience sympathy or consolation?

Like Dislike
1 2 3 4 5 6 7 8 9 10

Better from Worse from
1 2 3 4 5 6 7 8 9 10

How talkative are you in general?

Aversion to talking Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10

How afraid are you of the following? 1, never. 10, very afraid.

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10 Impending Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Failure

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/ Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 That something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorms

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

Are you forgetful of any of the following?
(1 not at all, 10 a lot)

1 2 3 4 5 6 7 8 9 10 Dates

1 2 3 4 5 6 7 8 9 10 Names

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Of what someone else just said to you

1 2 3 4 5 6 7 8 9 10 Of what you just said

1 2 3 4 5 6 7 8 9 10 Of words

How often do you make mistakes with the following?

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Words (reading)

1 2 3 4 5 6 7 8 9 10 Words (speaking)

1 2 3 4 5 6 7 8 9 10 Words (writing)

How sensitive are you to any of the following?

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

How do you handle conflict usually?

Quarrelsome Yielding
1 2 3 4 5 6 7 8 9 10

How are you in regard to authority?

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach (find fault, scold, or blame) others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest
1 2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary (Opposite to what is logically expected)

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you actually have sex?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you masturbate?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

What worries or concerns do you have about your sexual life?

Not enough desire Too much desire
1 2 3 4 5 6 7 8 9 10

Not enough sex Too much sex
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Lack of enjoyment

1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm

1 2 3 4 5 6 7 8 9 10	Impotence
1 2 3 4 5 6 7 8 9 10	Troubling fantasies or thoughts
1 2 3 4 5 6 7 8 9 10	Sexual confidence
1 2 3 4 5 6 7 8 9 10	Unusual sexual practices or desires

Health Information

Height____ Weight ____ Activity: Very High __ High __ Medium __ Low __

Overall health: Excellent ___ Good ___ Fair ___ Poor ___ Very Poor ____

In a few words, describe the condition(s) or symptom(s) that leads you to want Homeopathic treatment:

Seriousness: _____ About when did they start: _____

Can you think of anything particular that happened within six months or a year before these appeared? This should be something that affected you emotionally.

Describe those life experiences that have most deeply affected you, either positively or negatively.

Write a brief autobiography through to the present. This should only be an outline of the most important events. Your family history comes later.

Describe your early family life in some detail, through your early twenties. Then give a give a family history. List all relatives including siblings through grandparents with their ages. List their current and past illness as well as you can remember. If any of them have passed away, please give their ages at the time and the reason for death.

Childhood Diseases (please indicate dates and severity):

Asthma_____Chickenpox_____
Measles_____Mumps_____
Polio (location)_____ Rheumatic Fever_____
Rubella_____Scarlet Fever_____
Whooping Cough_____Other(s)_____

Indicate Immunizations:

DPT____ MMR____ HIB____ Polio____ Smallpox____ TB____ Pneumovac____

Flu shots? _____ Frequency? _____ When was the last one? _____

Describe any adverse reactions to any immune shots you have had:

As completely as possible, please give a medical history. This can be from memory if you do not have records, but please indicate that this is the case. We need dates, severity, treatment, and long term results of the condition and its treatment as clearly as you can. This history should include accidents and psychological incidents as well as physical illnesses. Indicate the dates and length and locations of any hospitalizations. Do not consider any information to be insignificant.

Please list all medications, herbs, stimulants and other modalities you are currently using. This includes Acupuncture, Chiropractic, Massage, Yoga, Reiki, Marshal Arts, etc.

Do you have any allergies? If so, to what and under what conditions.

For women only:

When did menstruation begin? _____(age).
Describe your menstrual cycle.

Describe your history of pregnancies, number including complications and way in which pregnancy finished.

Referral Information:

How did you hear about us? _____

If you have had Homeopathic treatment before, please list the practitioners and how to contact them. Please indicate for each one the condition that was treated and the results. If you know what remedies you took, you may list those as well.

Please sign and date this Intake Form. Do not forget to sign and date the disclaimer as well. We must receive that before we can begin.

Signed_____

Print Name _____

Date _____