Western North Carolina
NATUROPATHIC MEDICINE
Dr. Janet Opila-Lehman, ND

WellSpring, 966 Tunnel Road
Asheville, NC. 28805
j.opila.lehman@gmail.com

HOMEOPATHY INTAKE FORM

Today's Date:_____
Client's Name:_____Phone: _____
Birthday: _____Age: _____ □ Female □ Male
Height: _____Weight: _____Weight 1 year ago: _____

Address: _____
Email: _____
Occupation: _____Employer: _____

If someone other than the client is responsible for payment, please complete the following:
Name of responsible party: _____
Relationship to patient: _____ Phone #: _____
Email: _____

Emergency Contact Person: _____ Phone: _____
Relationship: _____

When did you last go to a doctor's office, clinic, or hospital? What was the reason?
_____
Are you currently under any physician(s) care? □ Yes □ No
If yes, physician name(s): _____
For what condition(s)? _____

Last blood work? _____
X-rays, CT scans, MRI? _____
Other tests?_____

NATUROPATHIC HEALTH CARE SURVEY

On a scale of 0-10 (0-none, 10=lots) how familiar are you with naturopathic medicine?
_____

What types of alternative treatment (ie Chinese Medicine, Herbs, Chiropractic, Massage, Homeopathy, etc.) have you used in the past?
_____

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Instructions for Homeopathic Intake 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 help determine which homeopathic 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 more troubled by clear weather. Circling a number closer to the cloudy end means that you are troubled by cloudy weather.

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

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.

1 2 3 4 5 6 7 8 9 10 **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

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Name: _____Date: _____

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

WEATHER/TEMPERATURE

Which weather conditions are you most troubled by? (1=none, 10=lot)

Cloudy 1 2 3 4 5 6 7 8 9 10

Wet 1 2 3 4 5 6 7 8 9 10

Dryness 1 2 3 4 5 6 7 8 9 10

Damp 1 2 3 4 5 6 7 8 9 10

Snow 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 1 2 3 4 5 6 7 8 9 10

Are you generally: Chilly 1 2 3 4 5 6 7 8 9 10 Warm

Circle which seasons cause you the most trouble?

Winter Spring Fall Summer

Are you worse being in the:

Mountains 1 2 3 4 5 6 7 8 9 10 Seashore

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ENERGY

What times of day are you generally the best (energy, mood, symptoms)?
_____

What times of day are you generally the worse? _____

Are you generally sensitive to and/or troubled by: (1=none, 10-lot)

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

1 2 3 4 5 6 7 8 9 10 Fever

SLEEP

Circle those which you experience:

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

Circle what you prefer:

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

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What position do you sleep in most often?

Right Side On Back Left Side On Abdomen

How much do you perspire?

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

Do you have difficulty waking?

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

Do you wake unrefreshed?

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

FOOD

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.

Tastes: (1=crave, 10-detest)

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

Foods: (1=crave, 10=detest)

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

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

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

How thirsty are you generally?

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

MENTAL and EMOTIONAL

Are you?

Frightened easily	1 2 3 4 5 6 7 8 9 10	Never afraid
Stingy	1 2 3 4 5 6 7 8 9 10	Overly generous
Thrifty	1 2 3 4 5 6 7 8 9 10	Extravagant
Hurried	1 2 3 4 5 6 7 8 9 10	Slow
Messy	1 2 3 4 5 6 7 8 9 10	Fastidious
Calm	1 2 3 4 5 6 7 8 9 10	Restless
Lazy	1 2 3 4 5 6 7 8 9 10	Always busy
Shy	1 2 3 4 5 6 7 8 9 10	Outgoing
Angry	1 2 3 4 5 6 7 8 9 10	Mild mannered
No religiousness	1 2 3 4 5 6 7 8 9 10	Highly religious
Obstinate	1 2 3 4 5 6 7 8 9 10	Yielding
Reckless	1 2 3 4 5 6 7 8 9 10	Coward

Do you worry about any of the following? (1=least, 10 = most)

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

1 2 3 4 5 6 7 8 9 10 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 (Changeable, erratic desires)

SOCIAL/RELATIONSHIPS

In regards to being with other people or in company?

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

Significant past emotionally traumatic events:

Resolved Grief Dwells on Past Inconsolable Guilt

Feeling towards people close to you:

Loving Affectionate Indifferent Resentment Hatred

Feeling toward spouse/lover:

Loving Affectionate Acceptance Dissatisfaction Disappointed
Indifferent Resentment Hatred

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FEELINGS

Feeling toward disease/condition?

Optimistic Doubtful of recovery Discouraged
Fearful Despair of recovery

Feelings toward life?

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

How much do you have the following symptoms? (1=never, 10=always)

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 Moody

Circle which best expresses your general mood.

Morose Sad Apathy/Indifferent Excitement Exhilaration

How do you experience sympathy or consolation?

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

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

How are you with the following?

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

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

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

How often and easily do you weep?

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

How often do you experience clairvoyance?

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

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How is your level of self-confidence?

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

How impulsive are you?

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

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

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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

How sensitive are you to any of the following? (1=none, 10=always)

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 1 2 3 4 5 6 7 8 9 10 Yielding

How are you in regard to authority?

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

How critical are you of others?

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

How critical are you of yourself?

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

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How honest are you?

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

How often do you have the following behaviors? (1=never, 10=all time)

1 2 3 4 5 6 7 8 9 10 Abusiveness

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

SEX

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

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

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

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

(1=never, 10-always)

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

What is most important to you in life? How are these values/goals currently in your life?

_____
_____
_____
_____

What are your top health concerns?

1._____
2._____
3._____

Any other comments/concerns?

_____
_____
_____
_____

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REVIEW of SYSTEMS

HEAD (1=never, 10=always)

1 2 3 4 5 6 7 8 9 10 Pain

1 2 3 4 5 6 7 8 9 10 Dizziness

Other: _____

EYES (1=never, 10=always)

1 2 3 4 5 6 7 8 9 10 Visual disturbances

1 2 3 4 5 6 7 8 9 10 Itching

1 2 3 4 5 6 7 8 9 10 Pain

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

Other: _____

EARS (1=OK, 10= very bad)

1 2 3 4 5 6 7 8 9 10 Hearing

1 2 3 4 5 6 7 8 9 10 Noise tolerance

Other: _____

NOSE (1=OK, 10=very bad)

1 2 3 4 5 6 7 8 9 10 Discharge

1 2 3 4 5 6 7 8 9 10 Nose bleeds

1 2 3 4 5 6 7 8 9 10 Allergies

TEETH

General status? _____

THROAT (1=OK, 10=very bad)

1 2 3 4 5 6 7 8 9 10 Inflammation

1 2 3 4 5 6 7 8 9 10 Soreness

Other: _____

MUSCULOSKELETAL (1=never, 10=always) Are you generally right or left handed?

1 2 3 4 5 6 7 8 9 10 Level of exercise (1=never, 10=lots)

1 2 3 4 5 6 7 8 9 10 Motion (1=like, 10=dislike)

1 2 3 4 5 6 7 8 9 10 Tingling

1 2 3 4 5 6 7 8 9 10 Stiffness

1 2 3 4 5 6 7 8 9 10 Pressure (1=tolerate ok, 10=very uncomfortable)

1 2 3 4 5 6 7 8 9 10 Joints (1=no pain, 10=severe pain)

Where? _____

1 2 3 4 5 6 7 8 9 10 Range of Motion (1=full range, 10=severe limitations)

Where? _____

Do you have any particular patterns of motion that you continually repeat?

_____

RESPIRATORY/CARDIOVASCULAR

1 2 3 4 5 6 7 8 9 10 Shortness of breath

1 2 3 4 5 6 7 8 9 10 Palpitations

1 2 3 4 5 6 7 8 9 10 Chest Tightness

1 2 3 4 5 6 7 8 9 10 Cough

1 2 3 4 5 6 7 8 9 10 Asthma

Other: _____

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GASTROINTESTINAL (1=never, 10=always)

1 2 3 4 5 6 7 8 9 10 Gas

1 2 3 4 5 6 7 8 9 10 Bloating

1 2 3 4 5 6 7 8 9 10 Diarrhea

1 2 3 4 5 6 7 8 9 10 Constipation

1 2 3 4 5 6 7 8 9 10 Pain

1 2 3 4 5 6 7 8 9 10 Nausea

1 2 3 4 5 6 7 8 9 10 Vomiting

What is the color of your stool?

Black Red Brown Tan Yellow Green

What is the consistency of your stool?

Solid sausage Loose sausage Pellets Mushy Runny

NEUROLOGICAL (1=OK, 10=always)

1 2 3 4 5 6 7 8 9 10 Tremors

1 2 3 4 5 6 7 8 9 10 Restlessness

1 2 3 4 5 6 7 8 9 10 Balance

1 2 3 4 5 6 7 8 9 10 Coordination

SKIN (1=ok, 10=always)

1 2 3 4 5 6 7 8 9 10 Rashes

1 2 3 4 5 6 7 8 9 10 Redness

1 2 3 4 5 6 7 8 9 10 Inflammation

1 2 3 4 5 6 7 8 9 10 Itching

1 2 3 4 5 6 7 8 9 10 Eruptions

1 2 3 4 5 6 7 8 9 10 Bruising

Do you have warts? Keloids? Moles? Other? _____

GENITO/URINARY

General status? _____

FEMALE (1=OK, 10=very, very bad)

1 2 3 4 5 6 7 8 9 10 Regularity

1 2 3 4 5 6 7 8 9 10 Flow

1 2 3 4 5 6 7 8 9 10 Pain

1 2 3 4 5 6 7 8 9 10 Cramping

1 2 3 4 5 6 7 8 9 10 Irritabiity

1 2 3 4 5 6 7 8 9 10 Headaches

MALE (1=never, 10=always)

1 2 3 4 5 6 7 8 9 10 Night time urination

1 2 3 4 5 6 7 8 9 10 Urgency/hesitancy/change in urinary stream

1 2 3 4 5 6 7 8 9 10 Prostrate enlargement

1 2 3 4 5 6 7 8 9 10 Impotence

1 2 3 4 5 6 7 8 9 10 Erectile dysfunction

Thanks so much for taking the time and energy to complete this form. Dr. Janet O-L.