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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?
____

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

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

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: ______________________

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 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 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

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

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

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

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

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?

____
____
____
____

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: ____

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.