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Full Initial Intake Questionnaire*:*

Name: _____ Date of First Visit:_____

Address_____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (work)_____

E-mail_____ Gender: female ___ male ___

Age _____ Date of Birth _____ Place of Birth_____

Are you: Married ___ Separated __ Divorced __ Widowed ___ Single ___ Significant Partnership _____

Live with: Spouse ___ Partner ___ Parents ___ Children _____ Friends ___ Alone ___

Occupation _____ Education _____

Employer _____ Hours per week _____ Retired_____

(Work address) _____ SS#_____

Next of Kin or other to reach in an emergency_____

Relationship_____ Address_____

Phone_(___)_____

How did you hear about our clinic? _____

Has another family member already been a patient at our clinic? yes_____no___

If yes: Name_____ Relationship_____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

HEALTH HISTORY QUESTIONNAIRE

Are you currently receiving medical or health care? Y N

If yes, where and from whom?_____

_____

If no, when and where did you last receive medical or health care?_____

_____

What was the reason?_____

_____

_____

Please list your primary health concerns in order of importance and approximate date when symptoms began:

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

Do you have any known contagious diseases at this time? Y N

If yes, please explain_____

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental influences? _____

FAMILY HISTORY

Check all that apply

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Age (if living)						
Health (G=good /P=poor)						
Age at death (if deceased						
Cause of Death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

General Information

Weight _____ lbs. Weight 1 year ago _____ lbs. Desired Weight _____lbs.

Maximum Weight _____ → When? _____

Height _____ Do you know your blood type? A B AB O + - (please circle)

What time during the day is your energy the best? _____am/pm
worst? _____am/pm

For the following sections, please circle Y (yes), N (no), or P (past)

Childhood Illnesses

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

Hospitalization and Surgery

What hospitalizations or surgeries have you had?_____

_____

_____

Special Studies

X-rays, CAT scans, or other studies you have had:_____

_____

_____

Electrocardiogram (EKG) Y N Electroencephalogram (EEG) Y N Angioplasty Y N

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Chicken pox	Y N
Hep B	Y N	Other _____	

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Steroids	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking, and **why you are taking them**? Please use back of sheet if needed.

1) _____ 6)_____

2) _____ 7)_____

3) _____ 8)_____

4) _____ 9)_____

5) _____ 10)_____

Food/Meals

Number of meals eaten per day: 1 2 3 more than 3
Where do you usually buy your food? _____

Who cooks the food you eat?_____

What restaurants do you frequent?_____

_____

Typical Food Intake

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Drinks: _____

_____

List any foods you crave regardless of their nutritional value: including sweets, chocolate, salt, sour, bread, rich/fatty, foods, etc. (i.e. comfort foods).____

_____

List the foods you **exclude** from your diet._____

_____

List any foods which do not settle well or cause an undesired reaction:_____

_____

_____

HABITS

Main interest and hobbies?_____

_____

Do you exercise?	Y		N			
If yes, what kind?_____				How often? _____		
Average 6-8 hrs. sleep?	Y		N	Enjoy your work?	Y	N
Sleep well?	Y		N	Take vacations?	Y	N
Awaken rested?	Y		N	Spend time outside?	Y	N
Have a supportive relationship?	Y		N	Read?	Y	N
Watch television?	Y		N → if yes, hours/day? _____			
Have a history of abuse?	Y		N → _____			
Any major traumas?	Y	P	N → _____			
Use recreational drugs?	Y	P	N → _____			
Been treated for drug dependence?	Y	P	N			
Use alcoholic beverages?	Y	P	N			
Treated for alcoholism?	Y	P	N → _____			
Do you use tobacco?	Y	P	N →if yes, packs/day?__ how long?___			
Do you eat three meals a day?	Y		N			
Do you eat out often?	Y		N → if yes, how often**?**_____			
Do you go on diets often?	Y		N			
Do you drink coffee?	Y	P	N → if yes, cups/day?_____			
Do you drink black or green tea?	Y	P	N → if yes, cups/day?_____			
Do you drink cola or other sodas?	Y	P	N → if yes, cans/day?_____			
Do you eat refined sugar?	Y	P	N			
Do you crave sugar?	Y	P	N			
Do you crave chocolate?	Y	P	N			
Do you add salt routinely?	Y	P	N			
Do you have a religious or spiritual practice?	Y	P	N			

If yes, please describe_____

How does your condition affect your daily life?_____

What do you think is happening?_____

_____

_____

What do you feel needs to happen for you to get better?_____

_____

What do you enjoy most in your life?_____

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition **you have now** **N** = never had **P** = a **past** condition you have had

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N

Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	Tuberculosis?	Y P N
Shortness of breath lying down?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bad breathe?	Y P N

Bowel Movements: How often? _____

Is this a change? If yes, please explain_____

Blood in stool?	Y P N	Black stools?	Y P N
Constipation?	Y P N	Diarrhea?	Y P N
Belching or passing gas?	Y P N	Pain or cramps?	Y P N
Hemorrhoids?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N		

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____		Are cycles regular?	Y N
Length of cycle? _____days		Bleeding between cycles?	Y P N
Duration of menses? _____days		Pain during intercourse?	Y P N
Painful menses?	Y P N	Clotting?	Y P N
Heavy or excessive flow?	Y P N	Discharge?	Y P N
Birth control?	Y P N → if yes, What type?_____		
PMS?	Y P N		
If yes, what are your symptoms?_____		Number of pregnancies _____	
_____		Number of live births _____	
Endometriosis?	Y P N	Number of miscarriages _____	
Ovarian cysts?	Y P N	Number of abortions _____	
Difficulty conceiving?	Y P N	Menopausal symptoms?	Y P N
Cervical Dysplasia?	Y P N	Abnormal PAP?	Y P N
Sexual difficulties?	Y P N	Chlamydia?	Y P N
Gonorrhea?	Y P N	Condyloma?	Y P N
Herpes?	Y P N	Syphilis?	Y P N
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N	Thrombophlebitis?	Y P N

The remaining questions, although some repetitive, are asked from a **constitutional homeopathic** perspective. The information you provide is best utilized when describe in **detail** and **in your own words** (ex: Back pain – like a knife stabbing, sharp pain, worse in AM, Worse in cold weather, better after moving around, etc…). The addition of a constitutional homeopathic remedy to your treatment plan can be a powerful tool towards stimulating your body towards health. For more info, please request our "homeopathy explained" handout.

HEALTH HISTORY QUESTIONNAIRE

Please list your primary health concerns in order of importance. In your own words, please describe the character of the disorder(s) and how it affects you. Use extra paper if necessary:

1)

2)

3)

4)

5)

ONSET ORIGIN OR CAUSE: When did most of these complaints begin? Was there some life experience which may have precipitated them, such as grief, shock, job or life status change, etc? Please explain in detail.

IMMUNIZATION HISTORY

Is there any history of negative effects post immunization(s)? Please explain.

HABITS

Please elaborate and mention any poor health habits like alcohol, smoking, drugs tobacco etc.

What are your main interests and hobbies?

What is your ideal vacation getaway? Do you make this a reality?

APPETITE

Grade as per preference +, ++ or +++/ dislike or aversion -1, -2 or –3.

Sweets ___
Salt and salty food (any extra salt) ___
Sour things like pickles/ vinegar ___
Seasoned and spicy foods ___
Milk ___
Meat ____, What kinds?_____
Eggs ___
Fried foods and fat ___
Please list specific **foods that you like** describe why _____
_____
Please list specific **foods that you dislike** and describe why
_____
Does eating decrease any complaints? Y___ N___, Please explain.

Any complaints **before** or **after** (circle one) eating? Y___ N___, For example:
Fullness of abdomen Y___ N___
Gas formation Y___ N___
Diarrhea Y___ N___
Can you remain hungry for hours on end? Y___ N___
Does any specific item or food cause discomfort e.g. acidity. headache, gas etc. Y___ N___ Please describe: _____
_____
Do you feel bloated, full, and heavy after eating Y___ N__

THIRST

In general, are you thirsty? Y____ N____
How much water do you drink at one time? (eg. Sips vs. Full Glass)
How many times per day do you drink water?
Do you drink water because you desire to, or because it's good for you? (circle one)
What do you prefer to drink, why, and at what temperature?

Please grade (+, ++, +++ for desire, or –1, -2, -3 for adversion) the following by preference:
Drinking cold/chilled water or drinks in the height of winter? _____
Drinking warm/ hot drinks in the height of summer? _____
Iced cold drinks/ water ____
Cold drinks _____
Room temperature drinks _____
Warm drinks _____
Very hot drinks _____

GENERALITIES

Please state how you are affected, what you prefer, or how you react to the following. Please elaborate if any symptoms are affected by these modalities:

1. Cold in general. cold air, drafts, cold winds etc.

2. Warmth in general. Warmth of bed or of room, external warmth etc.

3. Weather: dry, cold, wet weather, rain, cloudy, etc.

4. Thunder storms.

5. Open fresh air.

6. Sunlight and exposure to the sun.

7. Being near the sea? Being near the mountains?

8. Fasting or going without food for long periods of time.

9. Closed, crowded places (e.g.: elevators, etc.).

10. Exertion or physical strain? Mental strain?

11. Lack of sleep.

12. Do your troubles tend to occur or become worse periodically - (e.g. daily or alternate days. every week, yearly, during new or full moon etc...)

13. **In what part of your 24 hour day ...**

Do you feel the best? _____, Is there a specific time? Y____ N_____
Please explain.

Do you feel the worst? _____, Is there a specific time?
Please explain.

STOOL/BOWEL MOVEMENTS

Do you have regular and satisfactory bowel evacuations? Y____ N____

Is there a certain time of day your bowels evacuate? Y____ N____ , if yes, what time?_____

Typical stool color?_____
Typical stool consistency (watery → hard, small, thin, large, etc…)? _____
Frequent constipation? Y P N, Please explain.

Frequent diarrhea? Y P N, Please explain.

Strong odor? Y___ N___, Smells Like?_____
Any straining for stools, even though they might not be hard or constipated? Y___ N___
Any urgency for stools (e.g. do you have to run for stools first thing upon waking or immediately after eating)? Please explain: _____

Any pain, burning. bleeding with stools? Y___ N___, Please explain.

Piles (hemorrhoids), fissure, or fistula?

Do you have flatus (wind) along with stools and is it noisy?

URINE

Any increased frequency? Y___ N___, Day and/or night? Specific times?_____

Any smell (Odor) in the urine? Y___ N___, Please describe.

Any difficulty in passage of urine?

Any difficulty in retaining urine? Y___ N___, When?

Any associated complaints with urination? (ex. Can't pee with others around, must rock or stand before urination, loss of urine when coughing/laughing, etc…)

PERSPIRATION (SWEAT)

Do you perspire a lot? Y___ N___, If yes, is there an odor that you can describe?

Any particular part of your body that you perspire more on?

SEXUAL SPHERE FOR MEN

Any sexual disturbance(s)? Y___ N___, Please describe.

Excessive desire or aversion (please circle) to sex?

Disability or performance, premature ejaculation etc.?

Night time emissions?

Any history of sexual abuse, excessive masturbation etc.?

Any problem or complaints after intercourse?

SEXUAL SPHERE FOR WOMEN

Do you experience any sexual disturbances? Y___ N___, Please explain.

Excessive desire or aversion (please circle) to intercourse?

Any history of mental or physical abuse with sexual issues?

MENSES:

Are your menstrual cycles regular ____ or Irregular ___?
(Heavy ___, Scanty ___, Clotted _____, Dark or Light Color _____ or Odorous _____)

Do you experience complaints associated with, before or after menses (e.g. Headaches, irritability, premenstrual depression, diarrhea or constipation)? Y__ N___, Please explain.

Any heaviness or pain in breasts before menses? Any nodules in the breast or other premenstrual symptoms? Y___ N___, Please explain.

Any recurrent leukorrhea (white discharge), itching, burning or vaginal discomfort? Y___ N___, Please explain.

Any sense of weight or bearing down in your pelvis at any time? Y___ N___, Please explain.

MENOPAUSE:

Age of onset? _____

Any associated complaints at time at menopause e.g.: Hot flushes, palpitation, anxiety, depression etc.? Please describe:

SLEEP

Do you sleep well? Y___ N___, Please explain.

Any particular posture in which you sleep (e.g. lying on the sides, back, abdomen, fetal position, etc...)?

Do you feel refreshed after sleep? Y___ N___, Please explain.

Do you dream while sleeping? Y___ N___, if yes, do you remember them? Y___ N___

Any particular dream that is recalled and often repeated (e.g. frightening dreams of falling from a height, or being pursued by someone, death, etc.)? Y___ N___, Please explain.

Do any of your complaints become better or worse before, during or after sleep?
Y___ N___, Please explain.

Do you awake during your sleep? Y___ N___, if yes, what time? _____pm/am - _____pm/am

SKIN

Is there any current or past skin problem you have experienced (e.g. allergies, eczema, fungal infections, pigmentation etc.)? Y___ N___, Please explain with specific locations.

Any Itching or discoloration associated with it? Y___ N___, Please explain (ex. color, severity, etc…)

Any factors noticed that worsen the skin problem? Y__ N__, Please explain (ex. Temperatures, moisture, time of day, etc…)

Any factors noticed that improved the skin problem other than drugs? Y___ N___,
Please explain.

Any complaint or abnormality of your nails or the skin around them?

Any complaint of hair falling out, early graying, dandruff, etc.?

Any warts, moles, or birth marks on the body?

Any tendency to form excessive scar tissue (Keloids)? Y___ N___

Any tendency for wounds to suppurate (form pus easily)? Y___ N___

THE MIND

Have you noticed any marked changes in your mental state? Y___ N___, Please explain in detail.

Have you become or are you:

1. Anxious/afraid of anything (e.g. being alone, animals, darkness, disease, thieves, robbers, sudden noises etc.)?

2. Suspicious, doubting?

3. Impatient, hurried, or hasty?

4. Offended easily (can't take any criticism)?

5. Critical of others, always finding fault?

6. Irritable, quarrelsome, violent, etc.?

7. Depressed easily, sad or gloomy?

8. Timid/shy, or bashful?

9. Jealous or suspicious?

10. Anxious, restless, nervous or easily excitable? If yes, what aggravates this?

11. Are you silent. quiet. reserved, or talkative? Do you make friends easily?

12. Are you very affectionate? Do you demand love and warmth from others?

13. Do you cry easily? If yes, what makes you cry (e.g. grief of others, music, kind words of affection etc.)?

14. Do you like to be **consoled** or **alone** (please circle)when you are upset? Does sympathizing with you make matters better or worse? Please describe how you feel in these situations.

15. Do you give vent to your worries, emotions etc., or bottle them up inside or brood over them?

16. How do you stand and react to contradiction?

17 Do you have any Imaginary fears or feelings (e.g. that someone might want to harm you or your family, or you want to harm others, specific animals, etc.)?

18. How is your memory, ability to concentrate, etc...? Please describe:

19. Do you regret anything in life or resent certain people? If so, what, who, and why?

20. Do you feel humiliated or hurt easily? Would this give rise to any physical complaints?

21. Are you over conscientious about details, cleanliness, tidiness, punctuality etc.?
Are you a perfectionist by nature, being meticulous, fastidious and even finicky?

22. What is the greatest grief that you have felt in life? Also, what are the greatest joys you have experienced in life? Did any of your symptoms arise within 1 year of either of these situations? Please describe:

23. Can you easily mentally relax? For Instance, can you switch your mind off work, problems, children, etc.? Do you enjoy vacations and find that you totally relax when on a holiday, or do thoughts of work or what is happening at home keeps bothering you, etc.?

24. At work or with colleagues, subordinates, or your boss/seniors, how do you equate with them? Would reprimand or scolding from them upset you disproportionately to the problem?

25. How does music affect you? What type of music do you listen to?

26. Are there any thoughts that you find repeat themselves about specific past events? If yes, please describe and explain how this makes you feel.

YOU DID IT!!! Take a deep breath and reflect on whether any of these questions helped you understand more about yourself. Are there mental or spiritual issues you need to address?