Homeopathy of London
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Helping you achieve true health-naturally...

CONFIDENTIAL PATIENT INFORMATION

Pre-consultation Questionnaire
Homeopathic Client Information

Note to patient: Determining the proper remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation most effective, I request that you complete the following information form as in-depth and accurately as possible. If you have any questions, feel free to contact me. **Please note that all information provided is kept in the strictest confidence according to the laws of Homeopath – Patient confidentiality.**

Surname _____ First name _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Business Phone _____ E-mail _____

Date of initial consultation _____ Date of follow-up consultation _____

Date of Birth _____
Sex _____
Height _____
Weight _____
Weight (last year) _____
Hair colour _____
Eye colour _____
Marital Status _____
Occupation _____

CONFIDENTIAL PATIENT INFORMATION

Family Doctor:

Surname First name

Address

City Province Postal Code

Phone Fax E-mail

Referred By:

Surname First name Phone

Address E-mail

Medical Complaints (Please list your major medical complaints in order of importance to you.)

CONFIDENTIAL PATIENT INFORMATION

Medical History

Immunizations

	Yes	No
Diphtheria	☐	☐
Polio	☐	☐
Tetanus	☐	☐
Whooping Cough	☐	☐
Other	☐	☐

Allergies Yes / No
(if Yes, please list)

Have you suffered from:

	Yes	No
Abortion	☐	☐
Alcoholism	☐	☐
Depression	☐	☐
Drug Abuse	☐	☐
High / Low Blood Pressure	☐	☐
Miscarriage	☐	☐
PMS	☐	☐
Sexual Abuse	☐	☐
Other?		

Do you use the following;

	Yes	No
Alcohol	☐	☐
Antacids	☐	☐
Carbonated Bvgs	☐	☐
Coffee	☐	☐
Distilled Water	☐	☐
Fast Foods (often)	☐	☐
Fried foods	☐	☐
Laxatives	☐	☐
Margarine	☐	☐
Nonsugar Sweet.	☐	☐
Salt(without tasting)	☐	☐
Sweets	☐	☐
Tea	☐	☐
Tobacco	☐	☐

Usage of nutritional supplements?
(please list…vitamins, herbs, etc.)

What medications have you taken in the last year?

What treatments have / are you receiving?

What surgeries have you had during the course of your life?

What major injuries have you had during the course of your life?

Family health history;

	Age (at death)	Major Ailments
Mother		
Father		
Sister(s)		
Brother(s)		
Mat. GM		
Mat. GF		
Mat. U/A		
Pat. GM		
Pat. GF		
Pat. U/A		

Note: GM=Grandmother, GF=Grandfather, U/A=Uncles/Aunts

Have you suffered from any of the following conditions?

	Yes	No
Abscesses	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Chicken Pox	☐	☐
Cold Sores	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Frequent Colds	☐	☐
Gallstones	☐	☐
Gout	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Influenza	☐	☐
Kidney Disease	☐	☐
Leukemia	☐	☐
Lyme Disease	☐	☐
Malaria	☐	☐
Measles	☐	☐
Mononucleosis	☐	☐
Multiple Sclerosis	☐	☐
Mumps	☐	☐
Parasites	☐	☐
Pelvic Inflamm. Dz.	☐	☐
Peritonitis	☐	☐
Pleurisy	☐	☐
Pneumonia	☐	☐
Prostatitis	☐	☐
Psoriasis	☐	☐
Rheumatic Fever	☐	☐
Rubella	☐	☐
Scarlet Fever	☐	☐
Sexually Trans. Dz.	☐	☐
Skin Diseases	☐	☐
Sinusitis	☐	☐
Step Throat	☐	☐
Stroke	☐	☐
Sunstroke	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Typhoid Fever	☐	☐
Venereal Warts	☐	☐
Warts	☐	☐
Whooping Cough	☐	☐
Worms	☐	☐
Yellow Fever	☐	☐
Other		

CONFIDENTIAL PATIENT INFORMATION

Rate the following symptoms (where applicable) on a scale of 1 to 10 in relation to the **Intensity** of the particular symptom, where "**1**" implies slight discomfort and/or its affects are mild in severity and not limiting and "**10**" implies extreme discomfort and/or its affects are severe and limiting. Beside the symptom intensity, rate the **Frequency** at which you experience the symptom:
"O"= Occasionally "**F**"= Frequent "**C**"= Continual

Energy / Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ **Total**

Emotions
_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ **Total**

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical co-ordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ **Total**

Head
_____ Headaches / Migraines
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ **Total**

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
_____ **Total**

Ears
_____ Itchy ears
_____ Earaches or ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ **Total**

Nose
_____ Stuffy nose / Sinus problems
_____ Hay Fever / Allergies
_____ Sneezing attacks
_____ Excessive mucous formation
_____ **Total**

Mouth / Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
_____ **Total**

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest Pain
_____ **Total**

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ **Total**

Digestive Tract
_____ Nausea or vomiting
_____ Bloated feeling
_____ Belching
_____ Heartburn
_____ **Total**

Elimination
_____ Diarrhea / Constipation (please circle)
_____ Intestinal cramps
_____ Passing gas
_____ Frequent urination
_____ Painful urination
_____ Blood in waste products
_____ Mucous in waste products
_____ **Total**

Joints / Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ **Total**

Skin
_____ Acne
_____ Hives, rashes or dry skin
_____ Hair loss
_____ Flushing or hot flashes
_____ Excessive sweating
_____ **Total**

Weight
_____ Binge or compulsive eating / drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ **Total**

_____ **Grand Total**