# HOMEOPATHIC HEALING

Patient' Name _____ Date _____ Age_____

Date of Birth _____ Status: __ Single __ Married __ Divorced ___ Widowed ___ Separated

Address_____City_____Zip_____

Phone _____ (Cell Home Work) Number of Children_____

Email address _____

Occupation _____ Employer _____

Present MD and Phone # _____

How did you hear about Homeopathic Healing? _____

**Major Complaints in Order of Importance to You:**

| Complaint | Since | Causes/Symptoms |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**What Medications Have you Taken, or Are You Currently Taking?**

| Name | Since | Any Adverse Effects on You? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**What Treatments or Therapies Past/Present?**

| Treatment or Therapy | Since | Results |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Check any conditions/symptoms that you have experienced:**

- ❑ Abdominal cramping
- ❑ Abscess
- ❑ Alcoholism
- ❑ Allergies
- ❑ Amnesia
- ❑ Anaphylactic shock
- ❑ Arthritic symptoms
- ❑ Cancer
- ❑ Canker Sores
- ❑ Cold sores
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea/loose stools
- ❑ Difficulty Concentrating
- ❑ Emotional upset
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Eczema
- ❑ Energy drop after meals
- ❑ Fatigue
- ❑ Gall Stones
- ❑ Gas or bloating
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Heartburn
- ❑ Herpes
- ❑ Hepatitis
- ❑ Hives
- ❑ Indigestion
- ❑ Irritable Bowel
- ❑ Irritability
- ❑ Itching (skin or rectal)
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mood Disorder
- ❑ Nausea
- ❑ Nocturnal enuresis
- ❑ Parasites
- ❑ Periodontal Disease
- ❑ Pelvic Inflammatory
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Post-partum
- ❑ Psoriasis
- ❑ Prostatitis
- ❑ Red rash around mouth
- ❑ Rheumatic Fever
- ❑ Rhinitis
- ❑ Scarlet Fever
- ❑ Sexual Abuse
- ❑ Skin disorders
- ❑ Sinusitis
- ❑ Strep throat
- ❑ Stroke
- ❑ Sun stroke
- ❑ Swelling
- ❑ Syphilis
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Thyroid disorder
- ❑ Warts
- ❑ Whooping Cough
- ❑ Vomiting
- ❑ Wheezing
- ❑ Worms
- ❑ Other_____

**If Yes to any above, please explain: _____**

**_____**

**Any of the preceding conditions after which you have never been totally well since? Y____ N____**

**If yes, which? _____**

**What Operations have you had?** **When** **Any Complications?**

_____ _____ _____

_____ _____ _____

**What Injuries have you had?** **When** **Long Term Effects**

_____ _____ _____

_____ _____ _____

**Have you lost/gained any weight recently? Y N # of pounds _____**

**Do you exercise? _____ Type of Exercise? _____# times/week _____**

**Age at first Menstrual Cycle? _____Length of Cycle _____ Number of Pregnancies _____**

**Vaccinations you have had? _____**

_____

**Any Adverse Effects from Them? _____**

**How much of the Following Substances are you using? (times day/week)**

**Tobacco _____ Alcohol _____Coffee/Tea _____Recreational Drugs_____**

**Are You Currently Under the care of Another Physician?**

Physician For What Conditions Treatment(s)

_____ _____ _____

_____ _____ _____

**Have you ever been treated with Homeopathy before? Y_____ N_____**

**For what condition(s)? _____Remedies taken? _____**

**Is there anything else that you feel is important to your case that you would like to add?**

_____

_____

**HEALTH HISTORY OF RELATIVES**

**Indicate below which of the following ailments have affected your relatives:**

| | | | | | |
|---|---|---|---|---|---|
| Alcoholism | Asthma | Diabetes | Gout | Mental Illness | Skin Disease |
| Allergies | Cancer | Epilepsy | Hay Fever | Paralysis | Syphilis |
| Arthritis | Depression | Gonorrhea | Heart Disease | Pneumonia | Tuberculosis |

Any other major ailments? _____

| **Relative** | **Age (*if alive*)** | **Age (*at death*)** | **Ailment(s)** |
|---|---|---|---|
| Mother | _____ | _____ | _____ |
| Father | _____ | _____ | _____ |
| Brothers | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Maternal: | | | |
| Grandmother | _____ | _____ | _____ |
| Grandfather | _____ | _____ | _____ |
| Aunts/Uncles | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Paternal: | | | |
| Grandmother | _____ | _____ | _____ |
| Grandfather | _____ | _____ | _____ |
| Aunts/Uncles | _____ | _____ | _____ |

# Candida Symptom Checklist

*Please check as to whether you experience the following symptoms – never, sometimes, often, frequently.*

| **SYMPTOM:** | **Never** | **Rarely** | **Often** | **Constantly** |
|---|---|---|---|---|
| Headaches | | | | |
| Muscle aches | | | | |
| Joint pain | | | | |
| Energy drops | | | | |
| Cravings for sweets/breads/alcohol | | | | |
| Gas and bloating | | | | |
| Constipation OR diarrhea | | | | |
| Restless sleep or insomnia | | | | |
| Cold hands, feet or chilliness | | | | |
| (women only) PMS or menstrual irregularities | | | | |
| (women only) Endometriosis/Infertility | | | | |
| Pain or tightness in chest | | | | |
| Burning or tearing of the eyes | | | | |
| Irritability | | | | |
| Mood swings | | | | |
| Depression | | | | |
| Short term memory loss | | | | |
| Inability to concentrate or focus | | | | |
| Tendency to bruise easily | | | | |
| Sinus congestion or post nasal drip | | | | |
| Dry mouth or throat | | | | |
| Frequent or urgent urination | | | | |
| Numbness, burning or tingling (Usually in fingers, hands or limbs) | | | | |
| Skin rash or irritations (i.e. eczema/psoriasis/hives) | | | | |
| Reactions to tobacco smoke or heavy chemicals or perfumes | | | | |
| Difficulty losing weight on a diet | | | | |
| Loss of libido | | | | |
| Attacks of anxiety or crying | | | | |
| Occasional dizziness or loss of balance | | | | |
| Occasional sore throat (that is not a cold) | | | | |
| Allergies | | | | |