

**ATLANTA CLASSICAL HOMEOPATHY  
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**Homeopathic Intake Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birth Time:** \_\_\_\_\_

**Day of the week you were born:** \_\_\_\_\_ **Birthplace:** \_\_\_\_\_

**Children/ Names/Ages:** \_\_\_\_\_

**Specific philosophy or religion practiced now?** \_\_\_\_\_ **As a child?** \_\_\_\_\_

**Sex: M/F Marital Status: Single / Married / Living with partner / Separated / Divorced / Widowed**

**Live alone / Live with:** \_\_\_\_\_

**Emergency Contact / Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Have you had or are you familiar with homeopathic treatment? Y / N If yes, when and what?**

**List ALL medications, vitamins, or herbs you are currently taking, how long you taken each substance, and why.**

**Please list your mental, emotional, and / or physical health problems, from the most to the least significant.**

**1. Condition:**

**When did it begin?**

**What worsens the condition?**

**What improves the condition?**

**2. Condition:**

**When did it begin?**

**What worsens the condition?**

**What improves the condition?**

**3. Condition:**

**When did it begin?**

**What worsens the condition?**

**What improves the condition?**

**Is there any other information about your health that you would like to add?**

**What do you think is at the heart of your problems?**

**What feelings surface, as you identify the heart of your problems?**

**What goals or longtime dreams for yourself have you not been able to achieve?**

**What were your fears as a child?**

**What are your fears now?**

**What time of day do you experience the lowest energy and vitality?**

**Are most of your symptoms on the right or left side of your body?**

**Is there anything in the environment that is disturbing to you? (For example, some people have an aversion to the wind.)**

**How do you feel about thunderstorms?**

**How much do you like to dance, on a scale of 0 – 10?**

**How do you feel about having a bowel movement, when there is company in the house or when you are away from home?**

**Do you have a strong desire to travel?**

**List anything that is especially stressful to you now, such as relationships, job, school, finances, children, etc.**

**Please list in chronological order any major illnesses, accidents, grief, and emotional or physical traumas you have experienced. Give your approximate age at the time of the event. Please use the back of this page, if necessary.**

**Age:    Event:**

**Please state the health of your mother during her pregnancy with you.**

**Was your birth normal?**

**Were you breastfed?      How long?**

**Give any information you have about your health during your infancy?**

**How has your general state of health been? Excellent / Good / Fair / Poor**

**Do you wake up refreshed in the morning?**

What is your energy level on a scale of 1 -10? (Increasing scale)

Mark the childhood illnesses you have had and give you approximate age at the time:

Childhood Illness:	Age:
Polio	
Asthma	
Chicken Pox	
Rubella	
Measles	
Whooping Cough	
Scarlet Fever	
Mumps	
Other:	

Mark any immunizations you have received and give your approximate age at the time.

Immunization:	Age:
Smallpox	
DPT	
Typhoid	
Flu	
MMR	
Polio	
TB	
Hepatitis B	
Other:	

Did you experience any reaction to any immunization? Y / N If yes, explain.

Mark any tests that you have had. Indicate your age at the time.

Test	Age:
Chest X-ray	
Kidney X-ray	
G.I. Series	
Colon X-ray	
Gallbladder X-ray	
EKG	
TB test	
Other:	

Underline the following conditions that apply to you now and put an X beside the ones that have applied to you in the past.

- |                    |                 |                 |                 |
|--------------------|-----------------|-----------------|-----------------|
| Allergies          | Gonorrhea       | Cancer          | Frequent colds  |
| Diabetes           | Syphilis        | Tumors          | Bronchitis      |
| Excessive Drinking | Migraines       | Pneumonia       | Heart condition |
| Drugs Usage        | Chlamydia       | Rheumatism      | Sinusitis       |
| Eczema             | Anemia          | Warts           | Hepatitis       |
| Emphysema          | Arthritis       | Dehydration     | Easy bruising   |
| Liver disease      | Gout            | Herpes          | Obesity         |
| Jaundice           | Mental Problems | AIDS            | Asthma          |
| Tuberculosis       | Head injury     | Hypothyroidism  |                 |
| Easy Bleeding      | Kidney Disease  | Hyperthyroidism |                 |

**Hospitalizations**

Reason for Hospitalizations:

Date:

Mark any of the following that you use and indicate the amount or frequency of usage.

Substance / Item	Amount / Frequency
Cell Phones	
Coffee	
Cigarettes	
Alcohol	
Laxatives	
Cortisone medication	
Aspirin	
Water beds	
Hormone treatment	
Vitamins	
Electric blankets	
Medicinal herbs or teas	
Recreational drugs	
Birth Control pills	
Sedatives or tranquilizers	
Other drugs	
Diet pills	
Diet drinks	
Microwave oven	

Are you allergic to any drugs? Y / N If yes, which ones? What happens?

Are you allergic to any foods or other substances? Y / N If yes, which ones? What happens?

### Family History

For the following family members, please put an X beside the ones who are deceased. Indicate current age or age deceased, and list their ailments.

Family Member	Deceased?	Current Age/Age Deceased	Ailments
<b>Mother</b>			
<b>Father</b>			
<b>Sister/Brother</b>			
<b>Sister/Brother</b>			
<b>Sister/Brother</b>			
<b>Sister/Brother</b>			
<b>Maternal Grandmother</b>			
<b>Maternal Grandfather</b>			
<b>Paternal Grandmother</b>			
<b>Paternal Grandfather</b>			

Please mark any condition(s) that any of your blood relatives have had.

- |               |                  |                       |
|---------------|------------------|-----------------------|
| Allergies     | Eczema           | Heart attack          |
| Anemia        | Skin Disorder    | High blood pressure   |
| Arthritis     | Glaucoma         | Seizure / Epilepsy    |
| Asthma        | Gout             | Sickle-Cell Anemia    |
| AIDS          | Hay fever        | Stroke                |
| Easy bleeding | Gonorrhea        | Thyroid disorder      |
| Easy bruising | Syphilis         | Tuberculosis          |
| Cancer        | Venereal Disease | Learning Disabilities |
| Diabetes      | Alcoholism       | Suicide attempts      |
| Depression    | Abuse            | Addictions            |

### Military Service

Did you serve in the Military? Y / N If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

How long did you serve? \_\_\_\_\_

Did you contract any illnesses while serving? Y / N If yes, what?

Did you have any vaccinations during your time in the military? Y / N If yes, which

## **Dietary and Digestive Information**

**What is a typical day's diet?**

**Breakfast:**

**Lunch:**

**Dinner:**

**Snacks:**

**Drinks:**

**How frequently do you eat?**

**Who prepares your food?**

**What foods or other substances (tobacco, alcohol, coffee etc.) do you crave?**

**If everything were good for you, what would you most desire to eat?**

**Do any foods aggravate you? Y / N If yes, in what way?**

**How often do you eat restaurant food?**

**How much water do you drink?**

**What type of water is it? Tap / Distilled / Filtered / Spring / Well**

**How often do you have a bowel movement? \_\_\_\_\_**

**Do you strain during bowel movements? Y / N**

**Has your appetite changed? Y / N If yes, has it increased or decreased?**

## Symptoms

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Skin

Rough/Dry/Scaly/Bumpy/Itchy/Rashes/Warts/Moles/Cysts

Light/Dark patches of Skin

Increased hair growth in unusual places

Pimples: where?

Color changes in nails

Hives

Loss of hair: where?

Nails: ridges/pits/spots

Infections: how often?

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### Blood-Lymph-Immune System

Swollen or painful lymph nodes

Wounds that heal slowly

Difficulty stopping bleeding

Anemia

Bleeding from unusual places

Swollen glands

Easy bruising

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### Endocrine

Excessive hair growth: where?

Unexplained weight loss or gain?

Prefer hot weather

Prefer cold weather

Weakness

Can't stand the cold

Night sweats

Can't stand the heat

Chronic Fatigue

Cold hands / feet

Increased / decreased thirst

Increased / decreased hunger

Excessive sweating: where?

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Head

Dizziness

Double vision

Severe Headaches

Migraines

Seizures / Fits

Fainting spells

Injury / Blow to the Head

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### Eyes

Poor eyesight: near / far-sighted

Eyes sensitive to light

Frequent Infections

Injury to the eye

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### Ears

Discharge from the ears

Frequent infections

Hearing trouble

Pain in the ears

Injury to the ears

Ringling or other sounds in the ears

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### Nose

Nose bleeds

Sinus problems

Loss of smell

Injury to the nose

Difficulty breathing through the nose

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### Mouth

Sore Mouth / Tongue

Cold sores

Poor dentition

Dental fillings? What kind?

Bridges

Infections

Loss of teeth

Speech difficulty

Crown

Root canal

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**Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.**

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**Throat**

**Infections**

**Persistent hoarseness**

**Difficulty swallowing**

**Loss of voice**

**Swelling pain**

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**Neck**

**Stiffness: Improved by?**

**Worsened by?**

**Swelling: Improved by?**

**Worsened by?**

**Injury to the neck**

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**Respiratory System**

**Unexplained fever**

**Chest pain with breathing**

**Daily cough**

**Difficulty breathing at night**

**Night sweats**

**Infections**

**Shortness of breath**

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**Cardiovascular**

**Chest pain upon waking**

**Ankle swelling**

**Shortness of breath**

**Heart palpitations**

**Skipping heart beat**

**Fluttering**

**Leg vein trouble**

**Leg pain when walking**

**High blood pressure**

**Difficulty climbing stairs**

**Rheumatic fever: when?**

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Gastrointestinal

Color of stools: green / yellow / clay	Stool has foul odor / shows undigested food
Bad Breath	Bad taste in mouth / body odor (also feet)
Indigestion: fullness, bloating, sourness etc.	Heavy, full feeling after eating
Flatulence	Sleepy during the day
Symptoms aggravated by worry and tension	Loss of appetite
Constipation / diarrhea	Feel better / worse in the afternoon
Belching / stomach cramps / colicky sensations	Feel better / worse in the morning
Injury to the stomach	Weight gain / weight loss
Infection	Overweight

Nervous, shaky feeling, and / or headaches, relieved by eating sweets  
Irritable if late for a meal, miss a meal, or before breakfast  
Sudden, strong craving for sweets or alcohol  
Wake up hungry during the night

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### Spine and Extremities

Joint pain / Swelling / Stiffness / Tingling / Numbness	Burning of soles of feet
Muscle cramps	Spinal pain: where?
Backaches	Arthritis: where?
Unusual redness on palms of hands	Injury: where?

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### Nervous

Loss of balance	Involuntary movements
Paralysis	Tremors (shaking, trembling)
Lack of strength	Numbness
Convulsions (seizures, stiffness)	

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Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Mental

Nervousness	Cannot remember dreams
Restlessness	Trouble sleeping
Excessive worry	Frequent nightmares
Memory problems	Depression
Trouble concentrating	Easily angered
Crying Spells	Fearful
Mood swings	Hear voices
Excessive stress in life	See things others do not
Feelings of worthlessness	Suicidal

Feel better as a result of exercise  
Trouble getting along with people  
Loss of someone dear through death or separation  
Always put others' interests before mine  
Think others want to hurt me  
Don't know how to relieve stress  
Generally, late for appointments  
Frequently procrastinates  
Peculiar sensations: What?  
Obsessive habits or thoughts  
If you have recurring dreams, what are they about?

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### Genitourinary System

Frequent urination	Trouble starting urine
Painful urination	Blood in urine
What color is your urine?	Do you have night urination?

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### Male Problems

Prostate problems	Infection: Where
Discharge from penis	Infertility
Difficulty achieving or maintaining an erection	Injury: Where?
Painful erection	Premature ejaculation
Difficulty ejaculating	Testicles: Lumps / Swelling / Pain

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Female Problems

Discharge from vagina

Painful sex

No lubrication when aroused

Never or seldom have orgasms

Lumps in breast

Menstrual flow: excessive / absent

Bleeding or spotting between periods

Painful period: before/during/after

Pelvic pain

Infertility

Premenstrual symptoms: Cramping / Water retention / Breast Tenderness / Headaches / Depression / Irritability / Other?

Menopausal symptoms: Y / N If yes, since when? \_\_\_\_\_

What are your menopausal symptoms?

Infection: Where? When?

### Additional Questions for Women

Number of births \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Number of abortions \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Nursed children? Y / N If yes, how long? \_\_\_\_\_

Did you have any complications with the pregnancies? \_\_\_\_\_

How old were you when you started menstruating? \_\_\_\_\_

Do you have any nipple discharge? Y / N

How often do you have your period? \_\_\_\_\_

How long does your period usually last? \_\_\_\_\_

What is the number of tampons or pads used daily? \_\_\_\_\_

What is the date of your last period? \_\_\_\_\_

What type of contraception do you use? \_\_\_\_\_

Have you ever or do you now use any kind of hormone pill? \_\_\_\_\_

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### Final Remarks

Is there anything you would like to add?