ATLANTA CLASSICAL HOMEOPATHY

Sonja Benjamin
Certified Classical Homeopath
CCH, CHP, RSHom (NA), DIHom. M.Ed.
678-488-3467
swbenjamin@yahoo.com
www.AtlantaClassicalHomeopathy.com

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: _____ Marital Status: _____

☐Live alone ☐ Live with: _____

Emergency Contact /Relationship: _____

Phone: _____ Referred by: _____

Have you had or are you familiar with homeopathic treatment? ☐ Yes ☐ No 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.

Condition: _____

When did it begin?

_____

What worsens the condition?

_____

What improves the condition?

_____

Condition: _____

When did it begin?

_____

What worsens the condition?

_____

What improves the condition?

_____

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.

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. If additional space is needed, use the additional comments area at the end of this form.

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 recent 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 to 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	
☐ Mono	

Other: _____

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

If this intake is for a child and your child has been vaccinated, please email me a copy of their current vaccination record.

Immunization:
☐ Smallpox
☐ DPT
☐ Typhoid
☐ Flu
☐ MMR
☐ Polio
☐ TB
☐ Hepatitis B
☐ Hep A
☐ Hep C
☐ Haemophilus influenza type B (Hib)
☐ Meningococcal Disease
☐ Pneumococcal Disease
☐ Covid
☐ Covid Booster

Other: _____

Did you experience any reaction to any immunization? ☐ Yes ☐ No 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: _____

Put an X beside conditions that apply to you now.

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

List all hospitalizations with dates and reasons for the hospitalizations.

_____

_____

_____

_____

_____

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? ☐ Yes ☐ No If yes, which ones? What happens?

Are you allergic to any foods or other substances? ☐ Yes ☐ No 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 they deceased.

Family Member	Deceased?	Current Age/ Age Deceased
☐ Mother		
☐ Father		
☐ Sister/Brother		
☐ Sister/Brother		
☐ Sister/Brother		
☐ Sister/Brother		
☐ Maternal Grandmother		
☐ Maternal Grandfather		
☐ Paternal Grandmother		
☐ Paternal Grandfather		

Please mark any condition(s) any of your blood relatives have had, whether or not they are living or deceased.

☐ 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

Other: _____

Military Service

Did you serve in the Military? ☐ Yes ☐ No If yes, where? _____When? _____

How long did you serve? _____

Did you contract any illnesses while serving? ☐ Yes ☐ No If yes, what?

_____

Did you have any vaccinations during your time in the military? ☐ Yes ☐ No 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? ☐ Yes ☐ No 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? ☐ Yes ☐ No

Has your appetite changed? ☐ Yes ☐ No If yes, has it increased or decreased?_____

Symptoms

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

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? _____

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

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? _____

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

Head

☐ Dizziness
☐ Double vision
☐ Severe Headaches
☐ Migraines
☐ Seizures / Fits
☐ Fainting spells
☐ Injury / Blow to the Head

Eyes

Poor eyesight: ☐ near ☐ farsighted
☐ Eyes sensitive to light
☐ Frequent Infections
☐ Injury to the eye

Ears

☐ Discharge from the ears
☐ Frequent infections
☐ Hearing trouble
☐ Injury to the ears
☐ Ringing or other sounds in the ears
☐ Pain in the ears

Nose

☐ Nose bleeds
☐ Sinus problems
☐ Loss of smell
☐ Injury to the nose
☐ Difficulty breathing through the nose

Mouth

☐ Sore Mouth / Tongue
☐ Cold sores
☐ Poor dentition
☐ Dental fillings? What kind? _____
☐ Bridges
☐ Infections
☐ Loss of teeth
☐ Speech difficulty
☐ Crown
☐ Root canal

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

Throat

☐ Infections
☐ Persistent hoarseness
☐ Difficulty swallowing
☐ Loss of voice
☐ Swelling pain

Neck

☐ Stiffness: Improved by? _____
Neck Worsened by? _____
☐ Swelling: Improved by? _____
Worsened by? _____
☐ Injury to the

Respiratory System

☐ Unexplained fever
☐ Chest pain with breathing
☐ Daily cough
☐ Difficulty breathing at night
☐ Night sweats
☐ Infections
☐ Shortness of breath

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? _____

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

Gastrointestinal

Color of stools: ☐ green ☐ yellow ☐ clay
☐ Bad Breath
☐ Indigestion: fullness, bloating, sourness etc.
☐ Flatulence
☐ Symptoms aggravated by worry and tension
☐ Constipation/ diarrhea
☐ Belching ☐ stomach cramps ☐ colicky sensations
☐ Injury to the stomach
☐ Infection

☐ Stool has foul odor/ shows undigested food
☐ Bad taste in mouth / body odor (also feet)
☐ Heavy, full feeling after eating
☐ Sleepy during the day
☐ Loss of appetite
☐ Feel better/ worse in the afternoon
☐ Feel better/ worse in the morning
☐ Weight gain / weight loss
☐ 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

Spine and Extremities

☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Tingling ☐ Numbness
☐ Burning of soles of feet
☐ Muscle cramps
☐ Backaches
☐ Unusual redness on palms of hands

☐ Spinal pain: where?_____
☐ Arthritis: where? _____
☐ Injury: where? _____

Nervous

☐ Loss of balance
☐ Paralysis
☐ Lack of strength
☐ Convulsions (seizures, stiffness)

☐ Involuntary movements
☐ Tremors (shaking, trembling)
☐ Numbness

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

Mental

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

If you have recurring dreams, what are they about?

_____

_____

Genito•urinary System

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

Male Problems

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

Put an X beside the symptoms that apply to you currently. Where appropriate, fill in the blanks.

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: ☐ Yes ☐ No 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? ☐ Yes ☐ No 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? ☐ Yes ☐ No

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? _____

Final Remarks

Is there anything you would like to add?

Additional comments: