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.

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.

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 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	
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
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

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
Mother			
Father			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

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.

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?

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.

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

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.

Throat

Infections
Persistent hoarseness
Difficulty swallowing
Loss of voice
Swelling pain

Neck

Stiffness: Improved by?
Worsened by?
Swelling: Improved by?
Worsened by?
Injury to the neck

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?

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.

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
Muscle cramps
Backaches
Unusual redness on palms of hands

Burning of soles of feet
Spinal pain: where?
Arthritis: where?
Injury: where?

Nervous

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

Involuntary movements
Tremors (shaking, trembling)
Numbness

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.

Mental

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

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

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.

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 abortions ________

Number of pregnancies ________
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? ____________________

Final Remarks

Is there anything you would like to add? – (feel free to add to final blank page)

Additional comments: