

Initial Questionnaire

New Patient Registration

Name: _____

Mailing Address: _____

City: _____

State: _____ **Zip:** _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email address: _____

Age: _____ **Birthdate:** _____ **Sex:** _____

Occupation: _____

Education: _____

Relationship Status: _____

Religious Outlook: _____

How did you learn about this office?

Name of primary care physician or clinic, if any:

Please indicate the following:

Mother's name: _____ Date of Birth: _____

Father's name: _____ Date of Birth: _____

Initial Questionnaire

Health History

Please check **any** you have ever had:

- concussion
 - fainting
 - headaches
 - migraines
 - anxiety
 - depression
 - mood swings
 - alcohol abuse
 - drug abuse
 - numbness
 - dizziness
 - sweats
 - chills
 - sleep loss
 - weight loss
-
-
-
-
-
-

- eye problems
 - flashes in vision
 - halos in vision
 - blurred vision
 - crossed eyes
-
-
-
-
-

- TMJ
 - ringing in ears
 - hearing loss
 - earache
 - ear discharge
 - hay fever
 - hoarseness
 - sinus problems
 - nasal polyps
 - thyroid problems
-
-
-
-
-

- | | |
|--|--|
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> indigestion |
| <input type="checkbox"/> hives | <input type="checkbox"/> acid reflux |
| <input type="checkbox"/> rashes | <input type="checkbox"/> nausea |
| <input type="checkbox"/> itching | <input type="checkbox"/> stomach pain |
| <input type="checkbox"/> change in moles | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> scars | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> unhealed sores | <input type="checkbox"/> stomach ulcer |
| <input type="checkbox"/> difficult breathing | <input type="checkbox"/> IBS |
| <hr/> | <hr/> |
| <input type="checkbox"/> muscle pain | <input type="checkbox"/> colon polyps |
| <input type="checkbox"/> muscle weakness | <hr/> |
| <input type="checkbox"/> numbness | <hr/> |
| <input type="checkbox"/> tingling | <input type="checkbox"/> blood in urine |
| <input type="checkbox"/> joint pain | <input type="checkbox"/> frequent urination |
| <input type="checkbox"/> swollen joints | <input type="checkbox"/> leaky bladder |
| <hr/> | <input type="checkbox"/> painful urination |
| <hr/> | <hr/> |
| <input type="checkbox"/> asthma | <i>For Men:</i> |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> breast lump |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> ED |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> lump in testicles |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> penis discharge |
| <input type="checkbox"/> high BP | <input type="checkbox"/> sore on penis |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> gonorrhea |
| <input type="checkbox"/> low BP | <input type="checkbox"/> syphilis |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> chlamydia |
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> warts |
| <input type="checkbox"/> swollen ankles | <hr/> |
| <input type="checkbox"/> varicose veins | <hr/> |
| <hr/> | <i>For Women:</i> |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> abnormal Pap |
| <input type="checkbox"/> sores on gums | <input type="checkbox"/> breast lump |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> hot flashes |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> nipple discharge |
| <input type="checkbox"/> bloating | <input type="checkbox"/> painful intercourse |
| <input type="checkbox"/> bowel changes | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> constipation | <input type="checkbox"/> spotting |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> extreme cramps |
| <input type="checkbox"/> excess hunger | <input type="checkbox"/> gonorrhea |
| <input type="checkbox"/> excess thirst | <input type="checkbox"/> syphilis |
| <input type="checkbox"/> gas | <input type="checkbox"/> chlamydia |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> HPV |
| <input type="checkbox"/> rectal bleeding | <hr/> |

Initial Questionnaire

Serious Illnesses/Injuries:

What?

When?

Pregnancy History:

Child

Any Complications?

Born when?

Health Habits: How much?

How often?

Caffeine

Tobacco

Hospitalizations:

Rec drugs

For what reason? Hospital?

When?

Other

Occupational concerns: Work stress

 Exposure to Hazardous materials

 Heavy Lifting

 Long sitting**Family History:**

Family Year of Birth Year of Death Cause of Death History of Health Problems

Mother _____

Father _____

Brothers_____

Sisters _____

Initial Questionnaire for children

Please answer as many of the following questions as you can for and possibly with your child, in preparation for your initial homeopathic consultation. If you find this difficult to do, do not worry; we will explore these questions further during your session

Please print or write clearly.

Please bring these questions and answers to your initial homeopathic consultation. If you need more space to answer these questions, feel free to answer on a separate piece of paper.

1. What would you like homeopathy to do for your child?
 2. What are their physical complaints?
 3. What are their emotional / mental complaints?
 4. What are their behavioral complaints?
 5. When did their health problems start?
 6. Which health complaint is the most important to your child?
 7. Which health complaint is the most important to you?
 8. Which health complaint is the most important to the educational system?

Initial Questionnaire for children

9. In general, does your child run on the chilly side or the hot side or somewhere in between? Chilly children often complain about how cold it is and like lots of socks and sweaters. Warm children often complain about how hot it is and like to take off as much of their clothes as they can as often as they can.
 10. Does a particular part of their body get especially hot or cold at any time of the day or night? Or in special circumstances?
 11. In general, do you notice if your child is sensitive to or strongly affected by the various seasons of the year? Or the change of seasons?
 12. Are they sensitive to or strongly affect by any weather or climate condition including: hot weather, cold winds, wet days, sun exposure, cloudy days, fog, snow, cool breezes etc.?
 13. Is there a natural environment that your child prefers or feels relief from? Do the mountains, the desert, the seashore affect them?
 14. Are they affected by open air or drafts of air or stuffy rooms? In what way?

Initial Questionnaire for children

15. What times of day does your child feel most energetic?

16. What times of day do they feel most tired? How can you tell? What do they do or say?

17. What time of day are their symptoms most troublesome?

18. What kind of exercise or activities do they enjoy participating in? *For example: walking, hiking, horseback riding, bike riding, go cart racing, winter sports, summer sports, yoga, parties, dancing, singing.*? Do they feel better or worse from physical exertion or exercising?

19. Do they perspire? Do they perspire on a particular part of their body? Do they perspire most at a particular time of day or in a particular situation?

20. Do snug fitting clothing, such as shoes, turtlenecks, watchbands, waistbands, bras, pantyhose, or even rings on the fingers, bother them?

21. Are they bothered by noises, like chalk on a chalkboard or people chewing?

22. Are they bothered by light, like fluorescent lighting or car headlights or sunlight?

Initial Questionnaire for children

23. Are they bothered by odors, like perfume, gasoline, cleaning chemicals, room deodorizers or even flowers or essential oils?

24. Do they have any specific fears? For example: speaking up, taking tests, bugs, spiders, dogs, the dark, intruders, other animals, standing at a tall place looking down, being alone, being in an elevator, flying, in or on water etc.

25. What are they drawn to? For example: machines, people, animals, plants, rocks/minerals, butterflies, community activities, water, mountains etc. Do they have hobbies? Do they have any collections of things?

26. Do they have any problems with sleep?

27. What is their favorite sleep position? Is there a sleep position that is uncomfortable for them?

28. Do they now or in the past, talk, laugh, cry, moan, snore, scream, walk, jerk, or grind or clench their teeth in their sleep?

29. Do they suffer from restless legs in bed or leg cramps or growing pains?

30. Do they uncover any part of their body during sleep or do they like to be well covered?

Initial Questionnaire for children

31. Do they remember their dreams? Are there themes to their dreams? Do they have recurring dreams?

32. In general, do they wake up feeling refreshed in the morning?

33. What is their mood upon waking in the morning?

34. When do they get to bed at night? When do they get to sleep? When do they wake up? Do they resist going to sleep? Do you know why? Do they resist waking up?

Initial Questionnaire for children

35. What do they eat on an average day for breakfast? Does your child eat breakfast?

36. What do they eat on an average day for lunch?

37. What do they eat on an average day for supper?

38. What do they eat for snacks? And when?

39. How thirsty is your child? What do they like to drink? Do they prefer to use ice in their drinks?

40. What foods do they crave or love? What do they eat for pleasure?

41. What foods do they strongly dislike?

42. What foods cause symptoms when your child eats them? What reaction do you notice in your child?

Initial Questionnaire for children

43. Please **rate** the following, **10** being something your child loves. These could be foods you prohibit but they still love. Here are some food and drink suggestions; feel free to add your favorites.

Tastes &	_____	
Textures:	_____	
sweet		chocolate
sour		bread
salty	meat	pasta
spicy	fat on meat	cakes
smoked	fish	pastries
bitter	chicken	nuts
crunchy	shellfish	pickles
creamy	pork	fruit
slippery	bacon	lemons
	milk	oranges
Temperature:	cheese	raw veggies
hot food	yogurt	cooked veggies
cold foods	ice cream	salads
hot drinks	butter	onions
cold drinks	eggs	olives
ice	_____	garlic
Drinks:	_____	Peculiar things:
alcohol	_____	sand
coffee	_____	dirt
tea	_____	clay
soda	_____	chalk
juice	_____	coffee beans
sparkling water	_____	paste

Initial Questionnaire for children

44. Please attach or include your child's complete vaccination record, if possible.

45. What medications and/or supplements does your child receive and what are they for?

Please list:

a. Medication name:

for what condition:

b. Supplement name and **ingredients**: for what condition:
