New Client Registration

Name: _____

Mailing Address: _____

City: _____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell 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: _____

Name(s) of other health or mental health care providers:

_____

_____

Date of most recent: physical exam _____, dental exam_____,
eye exam_____

Please complete the following:

Mother's Name_____ Mother's Date of Birth: _____

Father's Name_____ Father's Date of Birth: _____

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
_____
_____
_____
_____
_____

__bruise easily
__hives
__rashes
__itching
__change in moles
__scars
__unhealed sores
__difficult breathing
_____
_____

__muscle pain
__muscle weakness
__numbness
__joint pain
__swollen joints
_____
_____

__asthma
__pneumonia
__bronchitis
__pleurisy
__chest pain
__high BP
__irregular heart beat
__low BP
__poor circulation
__rapid heart beat
__swollen ankles
__varicose veins

__ hemorrhoids
__ bleeding
__excess thirst
__ gas
__ bleeding gums
__ sores on gums
__difficulty swallowing
__poor appetite
__bloating
__bowel changes
__constipation
__diarrhea
__excess hunger

__indigestion
__rectal bleeding
__acid reflux
__hemorrhoids
__stomach pain
__vomiting
__vomiting blood
__stomach ulcer
__IBS
__colon polyps
_____
_____

__blood in urine
__frequent urination
__leaky bladder
__painful urination
_____
_____

FOR MEN:
__breast lump/pain
__ED
__testicle lump
__penis discharge
__sore on penis
__gonorrhea
__syphilis
__chlamydia
__warts

FOR WOMEN:
__abnormal PAP
__breast lump/pain
__hot flashes
__nipple discharge
__painful intercourse
__vaginal discharge
__extreme cramps
__spotting
__gonorrhea
__syphillis
__chlamydia
__HPV

Serious Illnesses/Injuries: **Hospitalizations:**

What? _____When? _____ What? _____When?___

_____ _____ _____ ___

_____ _____ _____ ___

Surgeries:

What? _____ When?_____

_____ _____

_____ _____

Health Habits: How much? How often? Occupational Concerns:

Caffeine _____ _____ _____Work stress
Tobacco _____ _____ _____Exposure to hazards
Recreational drugs _____ _____ _____Heavy lifting
Alcohol _____ _____ _____Long sitting
Other _____ _____ _____Long standing

Biological Family History:

	Year of Birth	Still living?	Year of Death	Cause of Death	Health History
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Please answer as many of the following questions as you can, 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. I will help you tell me the story of your condition.

Please print or write as clearly as you can.
Please return these questions and answers to me before 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 you?

2. What are your physical complaints?

3. What are your emotional and/or mental complaints?

4. When did your health problems start?

5. What health complaint is the most important to you?

6. In general, are you a chilly person or a hot person? Or somewhere in between? Chilly people often feel cold and carry warm clothing with them should they get a chill. Warmer people often feel uncomfortable in a warm room or in hot weather and may wear less clothing than others all year round.

7. Does a particular part of your body get especially hot or cold at any time of the day or night? Or in special circumstances?

8. In general, are you sensitive to or strongly affected by the various seasons of the year? Or the change of seasons?

9. Are you sensitive to or strongly affected by any weather or climate condition including: hot weather, cold winds, wet days, sun exposure, cloudy days, fog, snow, cool breezes etc.?

10. Is there a natural environment that you prefer or feel relief from? Do the mountains, the desert, the seashore affect you?

11. Are you affected by open air or drafts of air or stuffy rooms? In what way?

12. What times of day do you feel most energetic?

13. What times of day do you feel most tired?

14. What time of day are your symptoms most troublesome?

15. What kind of exercise or activities do you enjoy participating in*? For example: walking, hiking, horseback riding, car racing, winter sports, summer sports, yoga, parties, dancing, meditation, chanting etc.?* Do you feel better or worse from physical exertion or exercising?

16. Do you perspire? Do you perspire on a particular part of your body? Do you perspire most at a particular time of day or in a particular situation?

17. Does snug fitting clothing, such as turtlenecks, watchbands, waistbands, bras, pantyhose, or even rings on the fingers, bother you?

18. Are you bothered by noises, like chalk on a chalkboard or people chewing?

19. Are you bothered by light, like fluorescent lighting or car headlights or sunlight?

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

21. Do you have any specific fears? For example: speaking to a group, taking tests, bugs, spiders, dogs, other animals, standing at a tall place looking down, being alone, being in an elevator, flying, in or on water etc.

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

23. Do you have any tattoos? Where are they? What are they of? What is their significance?

24. Do you have any problems with sleep?

25. What is your favorite sleep position? Is there a sleep position that is uncomfortable for you?

26. Do you now or in the past, talk, laugh, cry, moan, snore, scream, walk, jerk, or grind or clench your teeth in your sleep?

27. Do you suffer from restless legs in bed or leg cramps?

28. Do you uncover any part of your body during sleep or do you like to be well covered?

29. Do you remember your dreams? Are there themes to your dreams? Do you have recurring dreams?

30. In general, do you wake up feeling refreshed in the morning?

31. What is your mood upon waking in the morning?

32. When do you get to bed at night? When do you get to sleep? When do you wake up?

33. Do you eat breakfast? What do you eat on an average day for breakfast?

34. What do you eat on an average day for lunch?

35. What do you eat on an average day for dinner?

36. What do you eat for snacks? And when?

37. How thirsty are you? What do you like to drink? Do you use ice in your drinks?

38. What foods do you crave or love? What do you eat for pleasure?

39. What foods do you strongly dislike?

40. What foods cause symptoms when you eat them? What reaction do you have?

41. Please rate the following foods and tastes on a scale of 1-10. 10 being something you love. Here are some suggestions – please feel free to add your own.

Tastes and Textures:	**Temperature:**	**Drinks:**
_____Sweet	_____Hot food	_____Alcohol
_____Spicy	_____Cold food	_____Coffee
_____Smoked	_____Hot drinks	_____Tea
_____Bitter	_____Cold drinks	_____Soda
_____Crunchy	_____Ice	_____Juice
_____Creamy		_____Sparkling water
_____Slippery		
_____Salty		
_____Sour		

Foods:

_____meat	_____fat on meat	_____fish	_____chicken
_____shellfish	_____pork	_____bacon	_____milk
_____cheese	_____yogurt	_____butter	_____ice cream
_____eggs	_____chocolate	_____bread	_____pasta
_____cakes	_____pastries	_____nuts	_____pickles
_____fruits	_____oranges	_____lemons	_____onions
_____cooked veggies	_____salads	_____ garlic	_____ raw veggies
_____olives	_____	_____	_____

Peculiar things:

_____sand _____dirt _____clay _____chalk _____paste _____other

42. What medications and or supplements are you taking and what are they for?
Please list with dosages:

Medication name	For what condition?	Start date?

Supplement name and ingredients	For what condition?	Start date?

Do you have any medication/supplement sensitivities or allergies? If so, please list the name and what happens to you with it.

Do you have any allergies or sensitivities? For example, foods, hayfever, animals. If so to what and what happens to you?

For Women:
Regardless of whether you are postmenopausal or post hysterectomy, please answer the following questions with as much detail as you can.

43. At what age did you begin to menstruate? Did you have any trouble or symptoms at that time?

44. Do you have any symptoms in the weeks before your menstrual flow? *This might include changes in mood, energy, appetite, sleep, breast tenderness, sex drive and overall fluid retention etc.* If you no longer menstruate, how was the premenstrual time in the past?

45. Are your menstrual cycles regular? From day 1 of your menstrual flow to day 1 of your next menstrual flow, how long is your cycle? If you no longer menstruate, how regular was your cycle in the past?

46. How many days does your menstrual flow last? If you no longer menstruate, how long did your flow last in the past?

47. Would you estimate that your menstrual flow is heavy or average or light? If you no longer menstruate, how heavy was the flow in the past?

48. Do you have any pain during your menstrual flow?

49 Do you have any other problems during your menstrual flow? If you no longer menstruate, how was your menses in the past?

50. What form of birth control do you use, if any? If you have used Birth Control pills or injections or IUDs or barrier methods, when did you use them? For how many years? Did you experience any side effects?

51. If you are now menopausal, what was the date of your last menstrual period?

52. Are you now or have you in the past, had any problems during peri-menopause or postmenopausal?

53. Have you been pregnant? Have you given birth? Have you had any miscarriages? Have you had any abortions?

54. If you have ever been pregnant, how were your pregnancies? Any difficulties or traumas or complications?

Pregnancy History:

Child	Any complications?	Born When?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

55. If you have had children, did you breastfeed them? Any difficulties?

56. Any problems with your breasts? Any lumps, cysts, inverter or retracted nipples, milk discharge, other discharge, PMS tenderness?

57. Any excess body hair, such as facial bearding, excess pubic hair, pubic hair extending to the navel, hair between the breasts etc.?