

HOMEOPATHIC INTAKE FORM

Date: _____

Name: _____

Address: _____

Telephone N: _____ E-mail: _____

Date of birth: _____ Age: _____ Sex: _____

Marital status: _____ Children: _____

Occupation (including duration and previous occupations): _____

Present complaint: _____

Family history:

Father: _____

Mother: _____

Wife/Husband: _____

Brothers: _____

Sisters: _____

Children: _____

Grandparents: _____

Please circle "Y" if you have been bothered recently by any of these problems
or "N" if you haven't.

- | | | | |
|-----|---------------------------|-----|----------------------------|
| Y N | Frequent/severe headaches | Y N | Rapid or skipped heartbeat |
| Y N | Back pains | Y N | Chest pains |
| Y N | Neck lumps or swellings | Y N | Shortness of breath |
| Y N | Loss of balance | Y N | Swollen feet or ankles |
| Y N | Dizzy spells | Y N | Armpit or groin swelling |
| Y N | Blackouts/fainting | Y N | Difficulty sleeping |
| Y N | Wear glasses | Y N | Motion sickness |
| Y N | Blurred vision | Y N | Excessive sweating |
| Y N | Eye sight worsening | Y N | Recurring indigestion |
| Y N | See halo or lights | Y N | Frequent belching |
| Y N | Eye pain or itching | Y N | Nausea and/or vomiting |
| Y N | Watery eyes | Y N | Pain in abdomen |
| Y N | Earache | Y N | Bloated abdomen |
| Y N | Hearing difficulties | Y N | Constipation |
| Y N | Running ears | Y N | Loose bowels |
| Y N | Noises in the ears | Y N | Black stools |
| Y N | Dental problems | Y N | Grey or whitish stools |
| Y N | Sore or bleeding gums | Y N | Pain in rectum |
| Y N | Sore tongue | Y N | Itching in rectum |
| Y N | Congested nose | Y N | Blood in stools |
| Y N | Running nose | Y N | Frequent urination |
| Y N | Sneezing spells | Y N | Involuntary urination |
| Y N | Head colds | Y N | Burning on urination |
| Y N | Nosebleeds | Y N | Black or bloody urine |
| Y N | Sore throat | Y N | Weak urinary stream |
| Y N | Difficulty swallowing | Y N | Difficulty starting urine |
| Y N | Hoarse voice | Y N | Constant urge to urinate |
| Y N | Wheezing or gasping | Y N | Aching muscles or joints |
| Y N | Frequent coughing | Y N | Swollen joints |
| Y N | Cough up phlegm | Y N | Back or shoulder pain |
| Y N | Cough up blood | Y N | Weakness in arms/legs |
| Y N | Chest colds | Y N | Painful feet |

- Y N Trembling
- Y N Numbness
- Y N Leg cramp
- Y N Skin problems
- Y N Scalp problems
- Y N Itching or burning skin
- Y N Bruise easily
- Y N Nervousness or anxiety
- Y N Nervous with strangers
- Y N Nail biting
- Y N Difficulty making decisions
- Y N Lack of concentration
- Y N Loss of memory
- Y N Lonely or depressed
- Y N Frequent crying
- Y N Hopeless outlook
- Y N Difficulty relaxing
- Y N Worry a lot
- Y N Scary dreams or thoughts
- Y N Feeling of depression
- Y N Shy or sensitive
- Y N Dislike criticism
- Y N Angered easily
- Y N Annoyed by little things
- Y N Family problems
- Y N Problems at work
- Y N Sexual difficulties
- Y N Change of sexual energy
- Y N Considering suicide
- Y N Loss or gain in weight
- Y N Loss of appetite
- Y N Always hungry
- Y N Fatigue or weariness
- Y N Fever or chills

- Y N Motion sickness
- Y N Night sweats
- Y N Hot flushes
- Y N Warmer or colder than others

Men Only

- Y N Burning or discharge
- Y N Swelling on testicles
- Y N Painful testicles

Women Only

- Y N Missed period
- Y N Menstrual problems
- Y N Bleeding between periods
- Y N Heavy bleeding
- Y N Bearing down feeling
- Y N Vaginal discharge
- Y N Genital irritation
- Y N Pain on intercourse
- Y N Swelling of breasts
- _____ N. Of pregnancies
- _____ N. Of births
- _____ N. Of miscarriages
- _____ N. Of premature births
- _____ N. Of caesarian
- _____ N. Of abortions

Comments or any other problems:
