The Family Wellness Medical Center

Homeopathy Intake Medical Chart Form

PLEASE READ THIS FIRST: Homeopathic medicine requires a comprehensive investigation into your health state. Thus, this intake form is a thorough and lengthy questionnaire. It will take some time to complete fully. If you are an adult please allow one hour minimum, and depending on your history, it may take additional time to complete.

In the process of determining the best possible homeopathic medicine (remedy) for you, we need your co-operation. HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know accurately your state of health. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

This information enables us to select the homeopathic remedy that works to remove your sickness. The medicine also makes you well as a whole person.

In order to treat at this level, it is necessary to find out a lot about you. Each one of these questions has a definite meaning and significance. There is not a single question asked, that is useless. Something that you may think is not related to your main concerns, may become the deciding factor in choosing the correct homoeopathic medicine. That is why you must be free and frank and give the fullest possible information on each point. Please read each question carefully, think and if necessary, consult someone close to you and then answer completely. Do not keep anything back. ***Remember, whatever you tell us will remain absolutely confidential.***

THIS QUESTIONNAIRE FORM HAS 8 PARTS:

1. About your past illnesses and family illnesses. Please take time to answer this part with the help of your family members before coming to us.
2. The history of your present illness.
3. Questions regarding all the specific parts of your body.
4. This part focuses on the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
5. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.
6. About the quality of your sleep and dreams.
7. About your child, or you as a child.
8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

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CONSTITUTIONAL HOMEOPATHIC INTAKE QUESTIONNAIRE

Name: _____ **Date:** _____

I. Current History

1. **What is your chief concern for which you seek homeopathic consultation?**

_____
_____
_____
_____

2. **When did this begin? How long have you been having these chief symptoms?**

_____

3. **Describe in more detail the symptoms; what were the initial symptoms and their location; then, the progression of symptoms, including how have they changed (evolved), and if so, describe what has changed, when and where?**

_____
_____
_____
_____

4. **What treatment(s) have you tried so far? What has been your response to these efforts?** _____

_____
_____
_____

5. **Please list all your current medications, and then, supplements, herbs, etc. Place a check (√) next to those that you believe are specifically related to the concern(s) which you wish to address homeopathically?** ☐ **no medications**

( )_____ ( ) _____
( ) _____ ( ) _____
( ) _____ ( ) _____
( ) _____ _ **Use backside if necessary, include O.T.C.**

6. **How would you describe your current overall health and happiness? How does this compare to one year ago, five and ten years ago?**

_____
_____
_____

7. Can you trace the origin of this heath problem or do you suspect any particular circumstance, accident, illness, incident or mental, or emotional upset may be associated with this condition? (e.g. shock after accident, (personal or global); family or relationship shift (death, divorce, difficulties); worry or loss; or situation in which you feel resulted in you overexerting, overwhelmed, excesses in diet, lifestyle, and or excessive exposure to cold, heat, loss of sleep, stress, trauma? Please share this experience (as it may be contributory).

_____
_____
_____
_____
_____
_____
_____

7. Do you have any allergies? Including drugs, and their side effects; foods, chemical, and environmental triggers? Did you previously have allergies?

_____
_____
_____

8. How was your health as a child? What do you know about your mother's pregnancy with you, your birth, and your first year of life?

_____
_____
_____
_____

9. Have you had the symptoms that you are currently seeking help for before in your life? Is so, when and under what circumstances?

_____
_____
_____
_____

(this space available for overflow from page one)

Constitutional Part II

Below are a list of things that you are exposed to. Each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of these factors? In what way do they affect you?

For instance take the factor "sun". Suppose by going in the sun you get a headache, then write "Headache " in the column next to "sun".

Take another example. if in hot weather you feel uneasy, then write "Uneasy" opposite to "Hot Weather " in the column.

In this way **write the effect of each factor on you. Especially write the effect each factor has on your main complaints.** For instance if your main complaint is asthma and this is worse when lying on the back then opposite to "lying on the back "write "asthma becomes worse"

Sometimes one factor may make you feel worse in some respect, and better in some other respect; for instance, cold air may cause headache, but headache make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

	Effect			Effect
Hot weather			Walking	
Cold weather			Running	
Rainy weather			Climbing stairs	
Cloudy weather			Going downstairs	
Change of season			Riding in bus, car etc.	
Thunder –storm			Lying	
Covering			Lying on back	
Warm bath			Lying on left side	
Sun			Lying on right side	
Cold bathing			Lying on abdomen	
Lying with head low			Drinking	
Sitting			After sexual act	

Sitting erect			Dust	
Standing			Smoke	
Looking up			Touch	
Looking down			Pressure	
Looking from high places			Massage	
Looking at moving object			Tight clothes	
Noise			Before sleep	
Sudden noise			During sleep	
Music			After sleep	
Light			After afternoon nap	
Strong smells			Loss of sleep	
When constipated			Before stools	
Before urine			During stools	
During urine			After stools	
After urine			Coughing	
Before menses			Sneezing	
During menses			Laughing	
After menses			Talking	
After Sweating			Reading	
When Fasting			Writing	
After eating			Stooping	
Before important engagement			Passing gas	
Before exams			After hair cut	
When angry			Combing hair	
When worried			Brushing teeth	
When sad			Moonlight	

After weeping			Opening the mouth	
Consolation /sympathy			Smoking	
In a crowd			Hanging the limbs	
In a closed room			Hanging the arms	
When thinking of illness			Near sea	
Full noon /new moon			Shaving	
Morning			Stretching	
Afternoon			Swallowing	
Evening			Listening to others talk	
Night			Vomiting	
Bathing			Yawning	
Draft air			Moving the eyes	
Biting or chewing			Opening the eyes	
Blowing nose			Closing the eyes	
When alone			Getting feet wet	
In company			Over eating	
Physical exertion			Working in water	
Belching			Fanning	

Now please review these factors from the perspective of your chief complaint. Please circle the strongest factors (3 -5 factors) that make your condition worse and then those (3-5 factors) that seem to help reduce/improve your primary complaint.

III. PAST HISTORY OF PREVIOUS DISEASES & DRUGS USED

Every disease, poisoning, drug or accident leaves its mark and remains in the system, much more than we imagine. Homeopathic treatment takes into account all these details of the past and works to removes all the weak points. Thus your body is strengthened. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illnesses so far suffered and on the next page give its relevant details.

Typhoid Cholera Food Poisoning Worms Diarrhea Dysentery	Measles German measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver (hepatitis) Spleen or Gall Bladder Disease	Miscarriage Abortion D&C, Currettings Sickness during Pregnancy etc. Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Any venereal Disease like Syphilis Gonorrhoea etc.	Any heart trouble , Blood pressure , Giddiness, HIV, AIDS	Nephritis (Kidney or urine trouble) Diabetes etc. Prostate trouble
Any operation such as Tonsils , Abdomen , Appendix , Hernia , Piles, Uterus , Renal Stone, Gall Stones, Phimosis , Hydrocele, Cataract etc. Mode of anaesthesia : general –local	Diphtheria, Septic Tonsils , Adenoids Recurrent infections – Sinusitis Bronchitis – Eosinophilia Cold 0-Fever-Chill . Pneumonia Asthma –Pleurisy—T.B.		Any serious shock , grief , disappointments, fright , mental upset, depression or nervous break down
Chronic Headaches, Numbness, Cramps, Fits , Convulsions, Polio, Paralysis etc. Meningitis –Any Lumbar puncture done.	Any major accident or injury to body or head. Any occasion of unconsciousness Any major bleeding from any part of the body.		Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Ulcers on any part of the body.

Past History, Continued

Diseases suffered from	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Use this space if there is any additional information regarding the above chart.

Please report any drugs, tonics, stimulants, remedies, etc. that have been used by you at any time in your life.

FAMILY HISTORY

How many brother(s) –sister(s) do you have? (Please including those who have died if any). Provide information about them in the table below. Indicate your position by writing 'SELF'.

SR.NO	**Brother /Sister**	**Alive /Dead**	**Age**	**Diseases suffered**
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PERSONAL HISTORY

Regarding your **birth,** did your mother have any problems during her pregnancy? Did she take drugs during the pregnancy? What were they? Was there any difficulty with your birth? (Give whatever details you know).

Development: at what age did you?

Teething		Urine Control Bed wetting etc.	
Sitting			
Standing		Eating indigestibles Like chalk , lime, earth. Slate-pen	
Walking			
Speaking		Any other problem about Your growth & development	

Tick mark (X) if you had any animal bites such as:

Dog		Rat		Snake		Scorpion	

Mention if any other animals including insects:

Did you take anti-rabies or anti –venom or any other treatment?

Vaccination & Inoculations:
Indicate number of times you were vaccinated for the following:

smallpox		Polio		MMR (measles, mumps, rubella)		Cholera
Hemophilus B		B.C.G.		Tetanus, Diphteria, Pertussus		Typhoid
Hepatitis A		Hepatitis B		Varicella		Influenza

Was there any reaction or particular trouble after any of above vaccinations or inocculations? If so give details:

Personal History, Continued

How is the health of your husband /wife/ domestic partner?

If you have **children,** complete the next section including living and dead. If dead, state causes:
Now, complete the following chart.

Child's name	Male/Female	Age	Diseases Suffered, health condition

Have you had any abortions, miscarriages or still births?

HABITS

Your Habits	How much
Smoking	
Snuff	
Chewing Tobacco	
Alcohol	
Tea / Coffee	
Sleeping Pills	
Laxatives /Purgatives	
Any other	

FAMILY INFORMATION

List of major diseases		Relationship	Alive /dead	Age	Diseases	Cause of death
Anemia		Paternal Grand Father				
Cancer		Paternal Grand Mother				
Diabetes		Maternal Grand Father				
Insanity		Maternal Grand Mother				
Rheumatism		Father				
T. B. /Pleurisy		Mother				
Leprosy			Diseases Suffered			
Epilepsy/fits		Paternal Uncles				
Bleeding tendency		Paternal Aunts				
Urticaria		Maternal Uncles				
Eczema		Maternal Aunts				
Asthma		Cousin Brother & Sister on Father's side				
Paralysis		Cousin Brother & Sister on Mother's side				
Hypertension						
Heart trouble						
Kidney disease						
Liver disease etc.						
		Did any of your relatives have trouble similar to yours				

IV. 'looking at the parts'

APPETITE AND THIRST

How is your appetite?

When are you hungry?

What happens if you have to remain hungry for long?

How fast do you eat?

How much thirst do you have?

Any particular time that you are especially thirsty?

Do you feel any change in your taste and feeling in your mouth?

Please Put one tick (X) if you Like / Dislike the food or if the food disagrees. Put two tick mark(XX) if you strongly Like / Dislike the food or if the food strongly disagrees.

	Like	Dislike	Disagrees			Like	Dislike	Disagrees
Bitter					Eggs			
Salt extra					Spicy food			
Sweet					Meat			
Sour					Fish			
Bread					Cabbages			
Butter					Onions			
Fats					Warm food/drink			
Milk					Cold food/drink			
Coffee					Fruits			
Mud/chalk					Anything else			

STOOL

Do you have any problem regarding your stools?

When and how many times a day do you pass stools?

When is it urgent?

Do you have any problems with bowel movements?

Do you have to strain for stool? Even if soft?

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas up or down?

URINATION & URINE

Any problem about the urine?

Any strong smell? Like what?

Do you have any trouble before, during and after passing urine?

Any difficulty about the flow? Slow to start, interrupted, feeble dribbling etc.?

Any involuntary urination? When ?

SWEAT/PERSPIRATION-FEVER-CHILL

How much do you sweat?

Where and on what parts do you sweat most?

Do you perspire on the palms or soles?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?

What is the smell like? (e.g. foul , pungent, sour, urinous)

What color does it stain the clothing? Is the stain easy to wash off or difficult?

Any symptoms after sweating?

When do you get fever or chill? What brings it on? Where in your body do you experience this? Any particular time of the day?

CHEST-HEART – COLD – COUGH

Do you catch cold often? if so, how?

Describe the symptoms, nature of discharge etc.

Is there any trouble with your CHEST or HEART?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

Do you have cough? Is it productive or non-productive?

Is it more at any particular time?

SEXUAL SPHERE (GENERAL)

What is your sexual orientation?

Any excessive indulgence in sex in past and present? Any effect on your health?

How do you feel after sexual intercourse?

Any particular feeling or symptoms appear before, during and after sexual intercourse?

Do you suffer from any sexual disturbance?

Any habit like (masturbation etc.) in the past as well as present? How often?

Have you had any Venereal disease? Syphilis? Gonorrhoea? Herpes?

Do you have increased desire or decreased desire for sex (libido)?

Do you use contraception? What is the method?

FOR MEN

Any difficulty with erections? Weak erection? Failing erection? Describe?

Wanted erection? Unwanted erection?

Any other trouble in sex? Describe in details.

FOR WOMEN

Menses: How are the periods; regular or irregular?

At what age did it start?

Was there any trouble then?

Mention number of days of flow.

Menstrual flow: Is there any change now in quantity, color, smell or consistency?

Are the stains difficult to wash out?

Have you noticed any variation in quality and quantity of flow during menses?

How and when?

Do you suffer in any way before, during or after menses? If so, describe:

What symptoms did you suffer during menopause?

Do you feel the internal parts coming down?

Is there any white discharge?

If so, mention the nature, color, consistency and smell of discharge.

When and under what circumstances is it more or less.

Has the discharge any relation to menses?

What is the effect of this discharge on your general feelings? or any of your symptoms?

Any itching, excoriation etc. due to discharge?

Do you pass any gas from vagina?

Any trouble with your breasts?

ANY COMPLAINTS ABOUT :

VERTIGO- Do you have giddiness – vertigo?

FAINTNESS: Do you ever feel faint?

HEAD: Do you get headaches?

EYES & vision:

EARS & sense of hearing:

NOSE & sense of smell:

FACE & facial expression:

MOUTH & sense of taste:

About LIPS, MOUTH, TONGUE etc.:

TEETH, GUMS e.g. carious teeth, bleeding gums.

Swollen gums:

LIPS: cracked, peeling of skin etc.

THROAT (including tonsils :

Any difficulty in swallowing?

Do you have any trouble in your BACK, LIMBS OR JOINTS? Describe in details:

If you have any pains, do they shift?

In what direction do they extend?

Is there any complaint of skin: such as itching, eruptions, ulcers, warts, corns, peeling etc.? (Describe its name)

Any change in color of the skin or spots on any part of the body?

Is there any complaint or abnormality of the NAILS or skin around?

Is there any complaint with the HAIR such as falling, graying, dandruff, dryness, oily, poor excessive or unusual growth?

Do wounds heal slowly?

Do you form keloid? Do wounds tend to form pus?

Have you a tendency to bleed?

Are your troubles one sided? Which side?

Or perhaps more on one side?

Do they proceed from one to the other side?

Or do they alternate or shift?

Is there any trembling? When?

Is there any sense of weakness? Where?

When is it more or less?

Is it in any particular part of the body?

PART V. The MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole.

In order to understand you we will be asking certain questions. Please answer them freely, carefully, and completely. This information will be very helpful in giving you the correct remedy. Also such a remedy will help improve your mental make up. So, Answer freely. Answer frankly. Answer completely.

Are you anxious? About which matters?

Are you fearful of anything such as:

Animals, people, being alone, darkness,

death, diseases, robbers, sudden noises,

thunder, of the future, of something

unknown, high places, etc.?

Are you doubtful or suspicious? Of what?

What are you jealous about?

Of whom? From what symptoms do you suffer when jealous?

In which matters are you impatient?

Hurried?

How long do you remember hurts caused to you by others?

How much revengeful are you?

What are you proud of? Does your pride get easily hurt?

Depressed, Brooding, etc.?

Do you ever become suicidal? When?

If so in what manner do you contemplate to end your life?

Even then, are you afraid of dying?

When are you cheerful?

Are you sexual-minded?

Any unwanted thoughts any time?

What are they?

Have you any imaginary sensations or fears?

Do you hear voices, or that you are called, or anything else in this line keeps on occurring in your mind unduly?

How is your memory?

For what is it poor? e.g. names, places, faces, what you have read, etc.

Do you weep easily?

What makes you weep?

How do you feel after weeping?

How do you feel if someone offers sympathy and consolation?

Are you easily irritated?

What makes you angry?

What bodily symptoms do you develop

when angry? e.g. trembling ,sweating etc.

Do you like company? Or like to remain alone?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What are the greatest griefs that you have gone through in your life?

What are the greatest joys that you have had in life?

What activities you deeply like?

Are there any matters which you deeply dislike?

In your opinion, which aspects of your mind

and moods are not agreeable to you . Inspite of

your awareness and maturity , are you

unable to change these aspects?

Give a clear cut picture of your situation in life and your relationship

with each of your family members, friends and associates in work .

How does the future look to you?

Are you worried or unhappy over any personal, domestic, economical , social or any other condition?

If so describe in detail:

Part VI **FOR CHILDREN or YOU AS A CHILD**

1) Please tick mark once (X) if the child or you as child had any of the following qualities: Tick mark twice (XX) if they are more intense:

	Tick Here		**Tick here**
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like :-	
Hyperactivity		Biting nails	
Destructiveness		Thumb –sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition-winning spirit		(b)shawls , handkerchiefs	
Sibling jealousy		(c) anything else	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness /Indolence	
Telling lies		Sensitive/Emotional	

2) Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy .Also describe the dreams the mother got during pregnancy.

3) Please describe any other aspects you feel are striking about the child .

4) Describe one incident from the child's life when he/she very upset.

Thank you for your efforts in completing this health questionnaire.
Patient's signature _____ **Dated** _____
Parent's signature (if patient is a minor)