the Homeopathic Plus centre
empowering lives every day

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ADULT Questionnaire

The information contained herein is strictly confidential. Please fill out this questionnaire completely and to the best of your knowledge. Even the smallest details are important.

Name: Marital/Relationship Status: Referred by:

Address: City: Province: Postal Code:

Home: Cell: Email:

Date: DOB: date/month/year Age:

Occupation: Employer: Phone: (work)

Name of Family Physician: Phone #:

Name of previous Homeopath: Phone #:

Emergency contact person: Home Phone #: Cell#:

Height: Weight: B.P. Pulse: Tongue:

1. What is your main health concern (HC), and when did it start?

2. Was it preceded by an event, accident or mental upset? (ie. shock, worry, dietary, overexertion, weather?)

3. Does anything make it:
   Better?
   Worse?

4. At what time of the day or night is main health concern the worst? Specify an hour if you can.

5. Do you have any other health concerns? Please list in order of importance for you, and the date of onset.?

6. Indicate your use of the following:

	Per day	Per week	Per month
Tobacco			
Alcohol			
Coffee			
Recreational Drugs			

7. What vaccinations have you had in the past 10 years? List any reactions. (Allergy, Fever etc)

8. Please check √ if you have ever had any of these conditions:

❑ Abscesses	❑ Headaches	❑ Pelvic inflammatory disease
❑ Alcoholism	❑ Heart trouble	❑ Pneumonia
❑ Anaemia	❑ Hypertension	❑ Prostate disease
❑ Appendicitis	❑ Hepatitis	❑ Rheumatic fever
❑ Arthritis	❑ Herpes	❑ Skin disease
❑ Asthma	❑ Influenza	❑ Strep throat
❑ Cancer	❑ Jaundice	❑ Sinusitis
❑ Chicken pox	❑ Kidney disease	❑ Stroke
❑ Cold sores	❑ Leukemia	❑ Gout
❑ Depression	❑ Liver disease	❑ Syphilis
❑ Diabetes	❑ Malaria	❑ Tonsillitis
❑ Eczema	❑ Measles	❑ Tuberculosis
❑ Epilepsy	❑ Mental illness	❑ Venereal warts
❑ Emphysema	❑ Mononucleosis	❑ Warts
❑ Gall stones	❑ Mumps	❑ Whooping cough
❑ Goitre	❑ Nosebleeds	❑ Worms
❑ Gonorrhoea	❑ Parasites	
❑ Others?		

9. What exercise do you do and how much?

10. List any treatments, medicines, supplements, homeopathic remedies you are taking.

Treatment or Medicine	When and for how long?	Effect on you?
Any major surgeries?	When?	Complications?
Major injuries?	When?	Complications or long-term effects?

11. *Questions about the weather and environment: you only need to answer those which apply to you.*

a. In which season does the weather aggravate your problem?

Summer Winter Spring Fall

b. Are you sensitive to light or noise? In what way?

c. How do you react to drafts of air (e.g. open window, having a fan on you) Do you like to sleep with the window open even -when it's cold out?

12. Have you ever suffered from eczema? ❑ Yes ❑ No If yes, what kind of treatment have had?

13. FAMILY HISTORY: Please indicate what ailments affect(ed) your family. These can include:

❑ Alzheimer's	❑ Epilepsy	❑ Skin diseases
❑ Alcoholism	❑ Gonorrhoea	❑ Syphilis
❑ Asthma	❑ Hypertension	❑ Tuberculosis
❑ Arthritis	❑ Heart disease	❑ Ulcers
❑ Cancer	❑ Hepatitis	❑ Diabetes
❑ Mental illness	❑ Depression	❑ Pneumonia
❑ Others* Specify below		

Relationship	Current Age	Age at Death	Cause of Death	Disease(s)
Mother				
Maternal Grandmother				
Father				
Paternal Grandfather				
Paternal Grandmother				
Sister(s)				
Brother(s)				

14. Have you ever had any breathing problems or Asthma? If yes, please explain.

15. Do you perspire a great deal? if so, when and where on the body? (feet, head, hair, armpits, etc.)

16. Do you suffer from constipation? ❑ Yes ❑ No If yes, how long have you had this problem?

17. Do you have any urinary problems? ❑ Yes ❑ No If yes, how long have you had this problem?

18. SYSTEMS REVIEW: Please check with a √ if you are currently suffering from, or with a Past if you have suffered from any of the following disorders in the past:

Skin:
❑ rashes ❑ eczema ❑ hives ❑ acne ❑ boils ❑ itching ❑ lumps ❑ dry hair
❑ dryness ❑ scaling ❑ moles ❑ warts ❑ falling/ thinning hair ❑ colour changes ❑ nail changes

Head:
❑ headache ❑ dizziness ❑ vertigo ❑ migraines ❑ head injuries

Eyes:
❑ eye pain ❑ tearing ❑ dryness ❑ glaucoma ❑ double vision ❑ cataracts ❑ blurring ❑ itching ❑ redness
❑ discharge ❑ impaired vision

Ears:
❑ ringing ❑ buzzing ❑ earache ❑ redness ❑ discharge ❑ infections ❑ impaired hearing

Nose/sinuses:
❑ frequent colds ❑ stuffiness ❑ hay fever ❑ nose bleeds ❑ obstruction ❑ loss of smell ❑ nasal discharge ❑ sinus problems

Mouth and throat:
❑ sore throats ❑ cankers ❑ dry lips ❑ bleeding gums ❑ receding gums ❑ loss of taste ❑ dental cavities

Neck:
❑ lumps ❑ goitre ❑ swollen glands ❑ pain or stiffness ❑ difficulty swallowing

Respiratory:
❑ cough ❑ sputum ❑ spitting blood ❑ wheezing ❑ asthma ❑ bronchitis ❑ pneumonia ❑ emphysema ❑ allergies
❑ difficulty breathing ❑ shortness of breath

Cardiovascular:
❑ palpitations ❑ chest pain on exertion ❑ blueness of lips ❑ swelling of ankles ❑ high blood pressure ❑ low blood pressure

Gastrointestinal:
❑ heartburn ❑ nausea ❑ vomiting ❑ constipation ❑ diarrhea ❑ gas ❑ belching ❑ bloating ❑ abdominal pain
❑ lack of appetite ❑ ineffectual urging ❑ haemorrhoids ❑ indigestion ❑ food allergies

Musculoskeletal:
❑ pain in joints ❑ swollen joints ❑ stiffness in joints ❑ broken bones ❑ muscle spasms ❑ cramps ❑ muscle twitching

Peripheral vascular:
❑ deep leg pain ❑ cold hands ❑ cold feet ❑ varicose veins ❑ ulcers ❑ extremity numbness ❑ extremity coldness
❑ extremity swelling

Neurological:
❑ fainting ❑ convulsions ❑ paralysis ❑ tremors ❑ numbness ❑ tingling ❑ weakness ❑ loss of memory ❑ speech problems
❑ loss of balance ❑ difficulty concentrating ❑ involuntary movements ❑ difficulty initiating movements

Endocrine:
❑ cold intolerance ❑ excess thirst ❑ excess hunger ❑ sudden weight gain ❑ sudden weight loss ❑ heat intolerance
❑ excess sweating

Reproductive system – FEMALES:
❑ menstrual problems ❑ sexual difficulties ❑ pain/dryness during intercourse ❑ problems achieving orgasm ❑ venereal disease
❑ difficulties conceiving or carrying a pregnancy to term

Reproductive system – MALES:
❑ testicular pain ❑ testicular masses ❑ sexual difficulties ❑ erectile difficulties ❑ fertility difficulties ❑ enlarged prostate
❑ venereal disease ❑ abnormal penile discharges

Mental/Emotional

19. What do you worry about? How do you deal with worries?

20. Do you cry easily? In what situations?

21. When you are upset, do you tend to tell a lot of people or keep it to yourself?

22. When and on what occasions do you feel frightened or anxious? Any fears (darkness, being alone, in crowds, altitude, flying, elevators, etc.)?

23. What are the greatest griefs that you have gone through in your life? How did you react to your grief?

24. Do you have a lack of self confidence and a poor sense of self worth?

25. a) What is your work occupation?

    b) What type of work would you prefer to do?

Food

26. How do you feel before, during and after meals? Any flatulence, heartburn, belching?

27. How do you feel if you go without a meal?

28. Do you crave for sweets or chocolates?

29. Do you consume excessive amounts of salt?

30. How much do you drink in a day? Include sodas, juice, coffee, tea, milk, and alcoholic beverages as -well as water. How thirsty do you tend to get?

Sleep

31. What hours do you sleep? Do you tend to wake up at a particular time? Why? What makes you restless or sleepy?

32. After sleeping. How do you feel in the morning?

Women

33. No. of pregnancies no. of children no. of miscarriages no. of abortions

34. At what age did your menses begin? or At what age did your menses stop?

35. How frequently do they (or did they) come?

30. What about their duration, abundance, colour, time of day when flow is greatest; any odour or clots?

Duration: Abundance: Colour: Time of day when flow is greatest:

Odour: Clots:

31. How do you (did you) feel before, during and after menses?

Before: During: After:

32. Have you suffered from any hairloss after giving birth?

Health History

34. How frequently do you get colds and flus?

35. Have you had any childhood illnesses twice, or in a very severe form, or after puberty?

36. Have you had vaccinations since the standard childhood ones? Have you ever had an adverse or unusual reaction to a vaccination?

38. Do you have any problems performing sex?

39. Do you tend to have any discharges (nasal, vaginal, etc.)? Color, consistency:

40. Do you tend to react to vitamins and herbs and/or need hypoallergenic vitamins? Yes No

41. Are you sensitive to paint fumes, exhaust, dry cleaning fluid, fragrances, etc.?

43. Construct a time line: Mention from birth on to the present day, all important events (emotional and physical traumas, heartbreaks, divorces, work-related events, diseases or traumas your mother had -while being pregnant with you, family stress, death in the family or of friends, disappointments, etc.) Mention the symptoms experienced at those moments or which you can date to those traumas. Please try to write at least one page outlining major events of your life.

44. What else would you like to tell me about yourself or your condition?