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Classical Homeopathy

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Adult Health History

Please print, fill out this form and bring it to your appointment.

Patient information

Name:____ Date: ____________Age : ___________

Address: ____

Email: ____

Cell Phone: __________________________

Home Phone: __________________________

Work Phone: _________________________

Best phone number to reach you weekdays, 9am-5pm: ________________________________

Occupation: ____

Marital/Partner status: ______________________________Number of children: _________

Main Health Concern

Please describe the main, most troubling issue, you would like help with.

____

____

____

____

____

How does this issue affect your life?

____

____

____

What makes the symptoms better or worse?

____

____

When did this start? ______________________________

List any life events that may have occurred BEFORE this started such as divorce, Illness, Travel, change of job or family/financial stress.

____

____

____

List any conventional or wholistic treatments you have used to try to resolve this issue. Did they work? ______________________________

____

____

Additional Health Issues

____

____

____

List any medications you are currently taking:

____

____

____

____

____

Supplements:______________________________

____

____

____

General health Assessment

If you have to any of the following conditions, rate them on a scale of 1-10

[10=intense, 1=practically absent].

Only answer those issues that are yours.

Leave the rest blank.

Sensitivities to:

Light__________ Noise___________ odors___________ Darkness__________ Heat_____________

Allergies:____________ Sun____________ Humidity__________Cold_________Rain___________

Digestion:

Bloating before a meal___________________Bloating after meal________________________

Lower bowel gas_____________ Constipation______________ Diarrhea____________________

Sour stomach____________heartburn or Reflux____________ Gut pain_________________

What kinds of food makes you truly feel better ? ___________________________________

worse? ____

Do you drink the following, and, if so how many per day?

Alcohol_____________Coffee____________Diet Drinks_________ Other____________________

Sleep

How well do you sleep? ____

Insomnia?_______________ Describe and how long to fall asleep? ____________________

____

What time do you wake during the night?____

How do you feel upon waking each day? ____

General Symptoms

Body temperature:

Do you currently run warm, hot or cold within your body?

____

Best weather for you:____

Worst weather or you:____

Energy Level

Rate your general energy level during the day [1=practically absent, 10 = very good]. ____

What time of day are you at your best? ______________________________________

Worse time of day?____

Do you smoke cigarettes/cigars and how many day?

____

Do you use recreational drugs and how much per day or week?

____

What do you do to relieve daily stress, even if it is only for the moment?

____

Do you feel better when you are moving around or resting?

____

Your personal Health History:

To the best of you knowledge, please list any other health issues, diagnoses or surgeries you have had in your life. Include the number of rounds of antibiotics used during that period. The issues could be mental, emotional or physical:

YEARS

0-5 ______________________________

5-10 ______________________________

10-15 ______________________________

15-20 ______________________________

20-30 ______________________________

30-40 ______________________________

40-50 ______________________________

50-60 ______________________________

60-70 ______________________________

70-80 ______________________________

90-100 ______________________________

Family Health History

Please list diseases / conditions of the following:

Mother ______________________________

Father ______________________________

Siblings ______________________________

Grandparents ______________________________

Random, odd or unusual symptoms:

Homeopaths find odd or seemingly 'quirky' symptoms about a person to be very individualizing and useful.

[An example might be: when you have a cold your left arm hurts or having one foot cold and the other hot].

Do you have any odd or quirky symptoms?

____

____

What is you desired outcome for your treatment?

____

____

____

Is there anything else you would like me to know about you or that was not asked on this form? ____

____

____

____

Is there something else you might want to possibly say about yourself in a future session, but are not quite ready to at this time?

Yes_______________No______________Not quite sure, we'll see........ ___________

This form will be held as 100% confidential at all times.

Thank You, Joy Pacitto MS, CCH