Homeopathic Intake Form

** These details are important for your Classical Homeopathy consultation with Carrie Hamilton.*
Please fill out as much as you are comfortable with.
** If you have not already filled out the All Worlds Health or All Worlds Pediatrics*
New Patient Forms, please fill those out in addition.

Today's Date: ___________________

Patient's name:

First	**Middle**	**Last**

Date of birth (Month/Day/Year): __________________________________ Age: _____________ Sex: _____________

Are you familiar with, or have you ever had **Homeopathic treatment**?

____
____
____
____

YOUR CHIEF COMPLAINTS:

In your opinion, what are your most important health problems? List as many as you can **in order of importance**:

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____
7) ____
8) ____

Comments about your most important health problems:

____
____
____
____
____

YOUR GENERAL HEALTH:

On a scale of 1 to 10 how do you rate your health now? ______________________________
The general state of my health has been: Excellent ______ Good ______ Fair _____ Poor ______
How is your general Vitality, Stamina and Energy? ______________________________
Are you a warm or chilly person? ____________________
Are u a thirsty person? ________ Do you prefer cold or warm drinks? _________

YOUR HEALTHY HISTORY:

When did your complaint or ailment begin? ______________________________
____
____
____

What do you think cause or has caused your ailment or complaint?
____
____
____
____

Have you had an experience (traumatic or otherwise) that did or still does affect you deeply? ________________
Explain ______________________________
____
____

What childhood illness have you had?

DISEASE:	WHEN:	DISEASE:	WHEN:
Rubella (3 day measles)	__________	Mumps	__________
Measles (two week)	__________	Chicken pox	__________
Whooping Cough	__________	Asthma	__________
Scarlet Fever	__________	Polio	__________
Rheumatic Fever	__________	Others	__________

YOUR HEALTH HISTORY

If you have had any of the following test or immunizations, place an (X) on the appropriate line and if you can, give the year you last had them

YEAR TESTS:	**YEAR IMMUNIZATIONS:**
________ Chest x-ray	________ Small pox
________ Kidney x-ray (Pyelogram)	________ Tetanus
________ G.I. Series	________ Polio
________ Color x-ray (Barium enema)	________ Typhoid
________ Gallbladder x-ray (Cholecystogram)	________ Flue
________ Electrocardiogram	________ Mumps
________ T.B. test	________ Measles
________ Other x-rays	________ Rubella
______________________________	________ Diphtheria
______________________________	________ Other

HOSPITALIZATIONS: (List as best you can)

Type of illness/operation	Date	Where

MILITARY SERVICE:

Where did you serve?____

When did you serve? ____

Did you get injuries, vaccinations or treatments of any kind while in service?

____

____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

NOW	PAST	NEVER		NOW	PAST	NEVER	
			Allergies				Emphysema
			Anemia				Heart Condition
			Arthritis				Kidney Disease
			Gout				Liver disease
			Hepatitis				Obesity
			Anorexia				Bulimia
			Asthma				High blood pressure
			Bleeding				Injury (serious)
			Bruising				Pneumonia
			Cancer				Rheumatism
			Tumors				Thyroid Trouble
			Colitis				Tuberculosis
			Convulsions				Epilepsy
			Mental disease				Ulcers
			Depression				Migraine Headache
			Diabetes				Drinking
			Drugs				Herpes
			Eczema				AIDS
			Sexually Transmitted disease (STD) (Venereal, Gonorrhea, Syphilis, other)				

Which STD's and when ____

WHICH OF THESE DO YOU USE:

YES		AMOUNT	YES		AMOUNT
	Coffee			Birth Control Pills	
	Cigarettes			Sedatives/Tranquilizers	
	Alcohol			Thyroid	
	Aspirin			Laxatives	
	Other Drugs			Cortisone	
	Electric Blanket			Hormones	
	Herbs & Teas			Vitamins	
	Recreational Drugs			Other Therapies	

FAMILY HEALTH HISTORY:

Please list ages, and if deceased, what they died of and at what age:

Relation	Living	Died	Cause	Age
Your other	_______	______	______________________________	______
Your father	_______	______	______________________________	______
Your brother (s)	_______	______	______________________________	______
	_______	______	______________________________	______
Your sister(s)	_______	______	______________________________	______
	_______	______	______________________________	______
Mother's side				
Your grandfather	_______	______	______________________________	______
Your grandmother	_______	______	______________________________	______
Father's side				
Your grandfather	_______	______	______________________________	______
Your grandmother	_______	______	______________________________	______

Has any BLOOD RELATIVE had any of the following?

YES	NO	DK (Don't know)		YES	NO	DK	
_____	_____	______	Allergies	_____	_____	_______	Hay Fever
_____	_____	______	Anemia	_____	_____	_______	Heart Attack
_____	_____	______	Arthritis	_____	_____	_______	High Blood Pressure
_____	_____	______	Asthma	_____	_____	_______	Seizure of Epilepsy
_____	_____	______	Bleeding	_____	_____	_______	Sickle Cell Anemia
_____	_____	______	Cancer	_____	_____	_______	Stroke

Has any BLOOD RELATIVE had any of the following?

YES	NO	DK (Don't know)		YES	NO	DK	
_____	_____	_______	Diabetes	_____	_____	______	Thyroid Trouble
_____	_____	_______	Depression	_____	_____	______	TB (Tuberculosis)
_____	_____	_______	Eczema	_____	_____	______	V.D. (Gonorrhea, Syphilis)
_____	_____	_______	Glaucoma	_____	_____	______	Gout

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

CARDIOVASCULAR SYSTEM

NOW	PAST		NOW	PAST	
______	______	Chest Pain when Walking	______	______	Leg Vein Troubles
______	______	Ankle Swelling	______	______	Leg Pain when Walking
______	______	High Blood Pressure	______	______	Shortness of Breath
______	______	Heart Palpitations (fluttering, pressure skipping going fast)			

ENDOCRINE – HORMONAL SYSTEM:

NOW	PAST		NOW	PAST	
______	______	Excessive Hair	______	______	Prefer Cold Growth Weather
______	______	Cold Hand or Feet	______	______	Unexplained Weight Loss/Gain
______	______	Prefer Hot Weather	______	______	Increased Thirst
______	______	Weakness	______	______	Increased Hunger
______	______	Can't Stand Cold	______	______	Can't Stand Heat
______	______	Chronic Fatigue	______	______	Sweating, Excess

SLEEP AND DREAMS:

Do you have any history of sleep problems, irregular sleep patterns? YES _______ No ______
If so, what problems? ____
____
Sleepy during day? YES ____ NO ____ When? ______________________________________
Do you usually dream? YES _____ NO ____ Do you remember your dreams? YES _____ NO _____
Is there a recurring theme to your dreams? YES ____ NO _____
If so what? ____
____
____
____
____
____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

NOW	PAST		NOW	PAST	
____	_____	Swollen or Painful Lymph Nodes	_____	_____	Chronic Fatigue
____	_____	Wounds Heal Slowly	_____	_____	Too Hot or Cold During Sleep
____	_____	Sleep Deprivation	_____	_____	Night Sweats

BLOOD, LYMPH, IMMUNE SYSTEM:

NOW	PAST		NOW	PAST	
_____	_____	Swollen or Painful Lymph Nodes	_____	_____	Chronic Fatigue
_____	_____	Wounds Heal Slowly	_____	_____	Fevers or Chills
_____	_____	Difficult Stopping Bleeding	_____	_____	Blood Transfusions
_____	_____	Anemia, Tires Easily	_____	_____	Re-Occurring Infections
_____	_____	Bleeding from Unusual Places	_____	_____	Bruises Easily
_____	_____	Swollen Glands	_____	_____	Unexplained Illness

RESPIRATORY SYSTEM:

NOW	PAST		NOW	PAST	
_____	_____	Unexplained Coughs	_____	_____	Chest Pain when Breathing
_____	_____	Mucus in Lungs	_____	_____	Shortness of Breath
_____	_____	Wheezing, Asthma	_____	_____	Chronic Cough
_____	_____	Difficulty Breathing	_____	_____	Lung Infections
_____	_____	Breathing at Night (wakes you up)	_____	_____	Tobacco Smoking

How far can you walk or how many stairs can you climb before having to stop? ___________________
____
____
What makes you stop? ____
____

Please mark 1(mild), 2(moderate) or 3(severe) if any of the following apply to you NOW or in the PAST.

NEVOUS SYSTEM:

NOW	PAST		NOW	PAST	
_____	_____	Loss of Balance	_____	_____	Paralysis
_____	_____	Convulsions, (seizures)	_____	_____	Lack of Strength
_____	_____	Tremor (shaking)	_____	_____	Numbness
_____	_____	Involuntary Movements	_____	_____	Nerve Pain, Sensations

Please mark 1(mild), 2(moderate) or 3(severe) if any of the following apply to you NOW or in the PAST.

SKIN AND HAIR:

NOW	PAST		NOW	PAST	
____	_____	Skin Rough, Dry, Scaly, Bumpy, Itchy (circle)	_____	_____	Pimples, Acne
____	_____	Warts, Moles, Cysts (circle)	_____	_____	Boils, Abscess
____	_____	Light or Dark Patches of Skin (circle)	_____	_____	Oily Skin
____	_____	Increased Hair Growth in Unusual Places	_____	_____	Dry, Cracked Skin
____	_____	Ages Spots	_____	_____	Eczema
____	_____	Color Changes in Nails	_____	_____	Dermatitis
____	_____	Hives, Rashes	_____	_____	Sensitive Skin
____	_____	Loss of Hair	_____	_____	Wrinkles, Premature
____	_____	Ridges, Pits or Spots on Nails	_____	_____	Blackheads, Clogged Pores
____	_____	Infections	_____	_____	Scars, Keloids

DIGESTIVE SYSTEM:

NOW	PAST		NOW	PAST	
____	____	Acid Reflux	_____	_____	Vomiting, Nausea
____	____	Blood in Stools	_____	_____	Diarrhea
____	____	Constipation	_____	_____	Fissures
____	____	Change in Bowel Movements	_____	_____	Anal Itching
____	____	Black or White Stools	_____	_____	Vomiting Blood
____	____	Heartburn	_____	_____	Gas and Bloating
____	____	Excess Belching	_____	_____	Yellow Jaundice
____	____	Stomach Pain and Aches	_____	_____	Trouble Swallowing
____	____	Distress from Fats or Greasy Foods	_____	_____	Worms, Parasites
____	____	Stools Yellow; Clay-Colored; Foul-Odored; Undigested Foods	_____	_____	Colitis
____	____	Bad Breath; Bad Taste in Mouth; Body Odor (including feet)	_____	_____	Surgeries, Injuries
____	____	Heavy, Full Feeling after Eating	_____	_____	Weight Gain or Loss
____	____	Excessive Lower Bowel Gas	_____	_____	Food Allergies
____	____	Stomach Pain Occurs 5 or 6 Hours after Eating	_____	_____	Special Diets
____	____	Diarrhea or Loose Stools			

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

NOW PAST
____ _____ Indigestion occurs immediately after eating
____ _____ Nervousness, shaky feeling, headaches; relieved by eating
____ _____ Irritable if late for meal, miss meal, or before eating breakfast
____ _____ Sudden, strong craving for sweets or alcohol
____ _____ Wake up at night feeling hungry
____ _____ Overweight
____ _____ Loss of appetite
____ _____ Sudden weight loss
____ _____ Sudden weight gain
____ _____ Infection
____ _____ Injury

How often do you have bowel movements? ________________ Do you strain at stool? YES ____ NO ____
Have you had a change of appetite? YES ____ NO ____ Increase or decrease? ___________________
What does your diet consist of? ____
____
____
How frequently do you eat? _____________________________Who prepares your food?________________
Do you snack? YES ____ NO ____ On What? ____
____
What food(s), condiments(s), or any other substances (tobacco, alcohol, coffee, etc.) do you crave? __________
____
____
Are you repelled by, or do you dislike any foods? YES ____ NO ____
What Foods? (Please identify) ____
____
____
Are there any foods that trouble or aggravate you? Do not agree with you? YES ____ NO _____
In what way? ____
____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

UROGENITAL SYSTEM:

NOW PAST
_____ _____ Frequent Urination
_____ _____ Night Urination
_____ _____ Trouble Holding

NOW PAST
_____ _____ Painful Urination
_____ _____ Trouble Starting Urine
_____ _____ Blood in Urine

MALE PROBLEMS:

NOW PAST
_____ ____ Have you ever had prostate problems
_____ ____ Discharge from penis
_____ ____ Difficulty achieving or maintaining an erection
_____ ____ Painful erection
_____ ____ Difficulty with ejaculation

NOW PAST
_____ _____ Lumps, swelling or pain in the testicles
_____ _____Infection
_____ _____Infertility
_____ _____Injury

What contraception do you use? ____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

FEMALE PROBLEMS:

NOW	PAST		NOW	PAST	
_____	_____	Discharge from vagina	_____	_____	Pelvic pain
_____	_____	Difficulty feeling sexually aroused	_____	_____	Bleeding/spotting between periods
_____	_____	No lubrication when aroused	_____	_____	Lumps in breast
_____	_____	Never or seldom have orgasms	_____	_____	Infertility
_____	_____	Menstrual flow is excessive/absent (circle)	_____	_____	Sex is painful
_____	_____	Pain before, during or after periods (circle)			

_____ _____ Infection – Location _________________ when _______________________

_____ _______ Premenstrual symptoms: cramping, water retention, breast tenderness headaches, depression, irritability, others ____

MENSES:

Period every ____________ days Regular? YES ____ NO ____

Period usually lasts ______________ days (average)

Number of tampons or pads used per day: ______________

Date of last period: ____________________

Number of births: _____________________ Nursed children? YES ____ NO ____ How Many? _______

Any trouble with lactation? YES _______ NO _________

Number of miscarriages: ______________ Number of abortions: ____________________

Dates: ____

Any complication(s) of pregnancy? YES _____ NO ______ If yes, please list __________________________

____

How old were you when you started having menstrual periods? _______________

Do you have any nipple discharge? YES _____ NO ______

What form of contraception do you use? ____

MUSCULOSKELETAL SYSTEM:

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

NECK:

NOW	PAST		NOW	PAST	
_____	_____	stiffness	_____	_____	whiplash
_____	_____	pain, swelling	_____	_____	injuries

SPINE AND LIMBS:

NOW	PAST		NOW	PAST	
_____	_____	Muscle Cramps	_____	_____	Burning of soles of feet
_____	_____	Backaches	_____	_____	Unusual redness of palms of hands
_____	_____	Injuries			
_____	_____	Joint pain, swelling, stiffness, tingling, numbness; Where? ________			
_____	_____	Other _______________________________________			

Have you ever had arthritis? YES ____ NO _____ When? ______________________________________

Where? __________________________________ What kind? __________________________________

Location?

____

____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

HAIR:	NOW	PAST		NOW	PAST	
	_____	_____	Dandruff	_____	_____	Hair Damage from Treatments
	_____	_____	Hair Loss	_____	_____	Dry Hair
	_____	_____	Baldness	_____	_____	Oily Hair

HEAD:	NOW	PAST		NOW	PAST	
	_____	_____	Dizziness	_____	_____	Migraines
	_____	_____	Sever Headaches	_____	_____	Fainting Spells
	_____	_____	Seizures or Fits	_____	_____	Nerve Pains
	_____	_____	Head Injuries	_____	_____	Facial Paralysis

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

EYES:	NOW	PAST		NOW	PAST	
	_____	_____	Eye Infections	_____	_____	Poor Eyesight (near or far-sighted)
	_____	_____	Light hurts eyes	_____	_____	Blurry Vision
	_____	_____	Double Vision	_____	_____	Weak Vision
	_____	_____	Glaucoma	_____	_____	Eye strain
	_____	_____	Bloodshot Eyes	_____	_____	Eye Injuries

EARS:	NOW	PAST		NOW	PAST	
	_____	_____	Discharge from Ears	_____	_____	Ear Infections
	_____	_____	Pain in Ears	_____	_____	Injuries
	_____	_____	Hearing Troubles	_____	_____	Ringing in Ears
	_____	_____	Excessive Earwax	_____	_____	Deafness

NOSE:	NOW	PAST		NOW	PAST	
	_____	_____	Nosebleeds	_____	_____	Difficulty in breathing through nose
	_____	_____	Mucus, Nasal Congestion	_____	_____	Sensitive Smell
	_____	_____	Sinus Problems	_____	_____	Post Nasal Drip
	_____	_____	Loss of Smell	_____	_____	Injuries

MOUTH:	NOW	PAST		NOW	PAST	
	_____	_____	Persistent Hoarseness	_____	_____	Sore Throats
	_____	_____	Difficulty Swallowing	_____	_____	Throat Sensations
	_____	_____	Loss of Voice	_____	_____	Choking
	_____	_____	Laryngitis	_____	_____	Throat Sores, Ulcers
	_____	_____	Mucus in Throat	_____	_____	Swelling

THROAT:	NOW	PAST		NOW	PAST	
	_____	_____	Sore Mouth or Tongue	_____	_____	Bad Teeth

_____	_____	Speech Difficulties	_____	_____	Mouth Sores, Ulcers
_____	_____	Loss of Teeth	_____	_____	Gums, Receding
_____	_____	Gum Infections	_____	_____	Tooth Cavities

Please mark 0 (not at all) 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

MENTAL AND EMOTIONAL:

NOW	PAST		NOW	PAST	
_____	_____	Anxiety, Excessive Worries	_____	_____	Feel better from exercise
_____	_____	Fear or Phobias	_____	_____	Lack of motivation
_____	_____	Nervousness, Restlessness	_____	_____	Mental Fatigue
_____	_____	Poor Self Confidence	_____	_____	Trouble Sleeping
_____	_____	Memory Trouble	_____	_____	Trouble Concentrating
_____	_____	Anger Spells, Irritable	_____	_____	Crying Spells
_____	_____	Worthlessness Feeling	_____	_____	Depression
_____	_____	Trouble getting along with people	_____	_____	Feel like killing myself
_____	_____	Mood Wings	_____	_____	Easily Upset or Disappointed
_____	_____	Obsessive Behaviors	_____	_____	Loss of Emotional Control
_____	_____	Brain Fog	_____	_____	Panic Attacks
_____	_____	Fearful of Public Speaking	_____	_____	History being abused
_____	_____	Loss of someone dear through death or separation	_____	_____	Emotional Shocks, Trauma
_____	_____	Always put others interest before mine	_____	_____	Suppressed anger or grief
_____	_____	See things others don't	_____	_____	Alcohol or drug addictions
_____	_____	Hear voices	_____	_____	Deep grief, hard to get over
_____	_____	Think others want to hurt me	_____	_____	Had excess stress in life
_____	_____	Don't know how to life relieve stress	_____	_____	Very sensitive emotions
_____	_____	Are you generally late for appointments?	_____	_____	Very shy, timid

_____ _____Peculiar sensations. What? ____

Where? ____

Rate your self-confidence (0 [no confidence in self] to 10 [most confident possible]): ____________
When and where are you happiest? ____
When and where are you unhappy? ____

Additional Comments: Is there anything else you wish to add? Also use the back of any pages if necessary.

____
____
____
____
____
____
____
____
____
____

Please sign your name below: patient signature, not parent or guardian (if applicable)