HOUSE of HEALTH
EST 2003

Homeopathy and Integrative Healthcare

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INITIAL CASE INTAKE FORM

1. Personal Details

Last name:_____ Middle initial:_____ First name:_____

Address:_____ City:_____ Postal code/ZIP:_____ Country:_____

Tel:_____ e-mail:_____ DOB:_____ Age:_____

Gender:____ Height:_____ Weight:_____ Marital status:_____ Occupation:_____

This consultation questionnaire is designed to assist you in constructing a clear picture of your condition, which will enable me as your homeopath to understand the nature of your ailments and create individualized protocol specific to you and your health needs.

Please be prepared to spend at least an hour working on this document. Take your time in answering the questions with as much detail as you possibly can. Once your intake form is received by my office I will contact you to book our initial consultation. Please make yourself available for at least 2 to 2.5 hours.

After the initial interview I will be spending 1-2 hours studying, analyzing the information and constructing a homeopathic healthcare plan for you. If necessary I may e-mail you with any further questions and clarifications before my initial work is finalized. Homeopathic medicines will be mailed out to you with instruction on how to take them.

2. **Reason for Visit**
   What is the reason for seeking homeopathic care? Describe the condition(s) you are seeking to address giving as much detail as possible.
3. **Current Symptoms**
   Please describe all your current symptoms in your own words providing details about the causality of those symptoms to the best of your knowledge.
   - 3.1. When did the complaint begin? Can you think of a possible cause leading to their onset?
   - 3.2. If you had experienced this complaint in the past, please describe how it started and what did you feel at that time?
   - 3.3. Provide details on anything that you feel is linked to the current complaint(s) that you perceive as unusual, rare and/or peculiar. Feel free to add any other information you find relevant.
4. **Create a timeline** – list all important events in your life (e.g. Birth of a child, death of a loved one, success at work, relationship breakdowns, etc.) both positive and negative that created significant impact on you. How did you feel about them? How do you feel about them now?
5. **General Symptoms:** By answering as many of these questions as fully as possible, you are helping me interpret what your body and unconscious mind are doing, so that I can find a homeopathic medicine for you.
   - 5.1. In which season do you feel less well?
   - 5.2. How does dampness affect you?
   - 5.3. Is there time during the day or night when you feel worse?
   - 5.4. How do you get affected by cold/hot/dry/wet/rainy/snowy weather?
   - 5.5. How do you feel when exposed to the sun?
   - 5.6. How does light affect you, if at all?

5.7. How does change of weather affect you?
5.8. How does wind affect you?
5.9. How does storm affect you?
5.10. How do you feel about warmth in general, warmth of bed, of the room, of the stove, of the sun?
5.11. How are you affected by draughts of air and temperature changes?
5.12. How do you react to extremes of temperature?
5.13. What position you like best (lying, sitting, standing)?
5.14. Are you prone to take colds easily and when?
5.15. What is the ideal kind of weather for you? Where would you choose to spend your vacation?
5.16. How do you keep your windows at night?
5.17. Do you like sports? What sports do you play?
5.18. How do you feel riding in cars, planes or sailing?
5.19. How do you feel before/during and after meals?
5.20. How would you describe your appetite? How do you feel if you miss a meal?
5.21. What kind of drinks do you prefer and how often do you drink? How many glasses of water/liquid do you consume in a day?
5.22. Are there any foods that disagree with your body? Anything that makes you sick and how do you react?
5.23. Do you consume alcohol? Any favourite alcoholic beverages?
5.24. Do you drink coffee? If yes, how many cups a day?
5.25. Do you smoke? If yes, how much in a day? How do you feel after smoking?
5.26. Are you taking any medications. Do you have any sensitivity to drugs?
5.27. What are the vaccinations you have had and were there any reactions from them (soreness, fever, discomfort, pain in the affected area, etc.)?
5.28. How do you feel at the seaside? How do you feel in the mountain?
5.29. Do you like taking baths or prefer quick showers?
5.30. How do you tolerate tight clothing, belts, collars, turtle necks?
5.31. How long does it take for any wounds, cuts to heal? How long do you bleed for?
5.32. Have you ever experienced dizziness? When?
5.33. Have you ever felt like fainting? In what circumstances?

6. Emotional Health

6.1. What are the greatest joys you have had in your life?
6.2. What are the greatest griefs you have gone through in your life?
6.3. Were there circumstances in your life that have put you in a position of being jealous?
6.4. Do you weep/cry? What can make you cry?
6.5. Do you have any worries? What do you worry about? How do you cope with worries?
6.6. Do you talk about your worries or you tend to keep them to yourself? Does consolation help?
6.7. Do you feel despair? On what occasions?
6.8. Do you have anxieties and fears? Please describe.
6.9. How do you feel in a room full of people? (e.g at the mall, church)
6.10. How do you react when you are angry? How do you feel when experiencing anger?
6.11. What complaints did you have following grief, disappointment, vexation, mortification, indignation, bad news, fright, etc.?
6.12. Are you self-conscientious about details? Do you like particular order of the possessions in your household?
6.13. How would you describe your memory? Your understanding? Your will? Your focus/concentration?
6.14. Do you feel sad or depressed and pessimistic? Is there particular time of day or circumstance when depression is at it's worse? Please describe.
6.15. How do you feel about death?

7. Food and Sleep

7.1. Do you have any cravings about particular food?
7.2. Is there any kind of food you have aversion for?
7.3. What kind of food makes you sick or you can not tolerate?
7.4. What about pastry and sweets?
7.5. What about spicy food and sour?
7.6. How do you like rich, fatty, oily, greasy food?
7.7. Do you like salt? Do you add it at the table?
7.8. Are you generally thirsty or not? What is preferred beverage?
7.9. Do you drink coffee/tea/wine/beer or other?

7.10. What is your favorite sleeping position?
7.11. Where do you put your arms during sleep? Do you like your head high or low?
7.12. At what time do you usually wake up? Do you feel refreshed after sleep?
7.13. Do you have insomnia? Do you have problems falling asleep? What time do you wake up in the middle of the night?
7.14. When are you sleepy?
7.15. What makes you restless or sleepy?
7.16. Do you have any dreams?
7.17. Is there anything peculiar associated with your sleeping pattern (e.g. Talking, walking, weeping, restlessness, snoring, excessive salivation, sleeping with your mouth open, teeth grinding, etc.)?

8. For female clients only

8.1. At what age did you have your first period?
8.2. How frequently do you get your periods? Are they regular or irregular?
8.3. Describe the onset, duration, nature of flow, colour, odour and any other symptoms you may experience around your period?
8.4. At what time in the 24-hours your period is at it's heaviest?
8.5. Do you experience PMS? Describe how you feel before, during and after your period?
8.6. Do you experience any emotional changes around the time of your period?
8.7. Have you ever been on birth control? When did you start and how long have you been taking the pill? Any adverse effects?
8.8. Were you ever diagnosed with PCOS, uterine fibroids, Endometriosis, ovarian cysts, ovarian insufficiency or any other conditions of the reproductive system?
8.9. Have you ever had any surgeries? Please give details.
8.10. Were you ever been placed on HRT?
8.11. Do you experience any pain or discomfort?
8.12. When was your last PAP smear test?
8.13. When was your last mammogram (clients over 40)?
8.14. Number of pregnancies and live births?
8.15. Number of miscarriages? Please give details.
8.16. Have you ever done fertility consultations and treatments?

For menopausal clients:

8.17. When was your last period?
8.18. Do you experience any discomfort?(e.g. Hot flushes, night sweats,etc)
8.19. What generally ameliorates and aggravates your complaints?

9. Bodily functions and Discharges. I am interested in the sensations, their location, what modifies them and what accompanies them. Skin symptoms need to be described as I cannot see them. Are they dry, moist, oozing? What is the nature of the discharge? Where did they start, and in which part of your body? And when - after a vaccination or after a grief or other major trauma? When do they come and go?

9.1. Do you have any problems affecting the senses, vision, hearing, smell, taste?
9.2. Do you have any dental problems?
9.3. Do you have any skin problems like eczema, psoriasis, warts, tumours, unusual growths and eruptions?
9.4. Do you have any troubling symptoms in regards to temperature, sweat, mucous, discharges, smells?
9.5. Anything troubling in regards to bowels, urine and genitals?
9.6. Do you feel any pain? If yes, give details and describe the nature of your pain (e.g. Throbbing, stabbing, burning as well as other associated sensations).
9.7. Complete the sentence, “It feels as if....” about all your pains and discomforts.
9.8. Do you have an official diagnosis for your ailments? If so by whom? Please give details about it.
9.9. Are you currently taking any conventional medication, homeopathic remedy, herbs, vitamin or mineral supplements? Please list all.

10. Personal and family history

10.1. Provide detail on your medical history listing all significant events since childhood, including injuries, hospitalization, accidents, illnesses.
10.2. Provide as much information as you can regarding the medical history of immediate family and grandparents.
10.3. Please describe your circumstances at home and any important relationships.
10.4. What would you like to do in your free time?

10.5. This section is reserved for any important information and aspects of your life that have not been covered above. Take as much space as needed.