New Patient Registration

Name: _____

Mailing Address: _____

City: _____

State: _____ **Zip:** _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email address: _____

Age: _____ **Birthdate:** _____ **Sex:** _____

Occupation: _____

Education: _____

Relationship Status: _____

Religious Outlook: _____

How did you learn about this office?

_____

Name of primary care physician or clinic, if any:

_____

Name(s) of other health or mental health care providers:

_____

_____

Please indicate the following:

Mother's name: _____ Date of Birth: _____

Father's name: _____ Date of Birth: _____

Health History

Please check **any** you have ever had:

__concussion
__fainting
__headaches
__migraines
__anxiety
__depression
__mood swings
__alcohol abuse
__drug abuse
__numbness
__dizziness
__sweats
__chills
__sleep loss
__weight loss
_____
_____
_____
_____

__eye problems
__flashes in vision
__halos in vision
__blurred vision
__crossed eyes
_____
_____
_____
_____

__TMJ
__ringing in ears
__hearing loss
__earache
__ear discharge
__hay fever
__hoarseness
__sinus problems
__nasal polyps
__thyroid problems
_____
_____
_____

__bruise easily
__hives
__rashes
__itching
__change in moles
__scars
__unhealed sores
__difficult breathing
_____
_____

__muscle pain
__muscle weakness
__numbness
__tingling
__joint pain
__swollen joints
_____
_____

__asthma
__pneumonia
__bronchitis
__pleurisy
__chest pain
__high BP
__irregular heart beat
__low BP
__poor circulation
__rapid heart beat
__swollen ankles
__varicose veins
_____
_____

__bleeding gums
__sores on gums
__difficulty swallowing
__poor appetite
__bloating
__bowel changes
__constipation
__diarrhea
__excess hunger
__excess thirst
__gas
__hemorrhoids
__rectal bleeding

__indigestion
__acid reflux
__nausea
__stomach pain
__vomiting
__vomiting blood
__stomach ulcer
__IBS
__colon polyps
_____
_____
_____

__blood in urine
__frequent urination
__leaky bladder
__painful urination
_____
_____

For Men:
__breast lump
__ED
__lump in testicles
__penis discharge
__sore on penis
__gonorrhea
__syphilis
__chlamydia
__warts
_____
_____

For Women:
__abnormal Pap
__breast lump
__hot flashes
__nipple discharge
__painful intercourse
__vaginal discharge
__spotting
__extreme cramps
__gonorrhea
__syphilis
__chlamydia
__HPV
_____
_____

Initial Questionnaire

Serious Illnesses/Injuries:

What?	When?
_____	_____
_____	_____
_____	_____
_____	_____

Health Habits:

	How much?	How often?
Caffeine	_____	_____
Tobacco	_____	_____
Rec drugs	_____	_____
Other	_____	_____

Occupational concerns:

__ Work stress

__ Exposure to Hazardous materials

__ Heavy Lifting

__ Long sitting

Pregnancy History:

Child	Any Complications?	Born when?
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Hospitalizations:

For what reason?	Hospital?	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Family	Year of Birth	Year of Death	Cause of Death	History of Health Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Initial Questionnaire for children

Please answer as many of the following questions as you can for and possibly with your child, in preparation for your initial homeopathic consultation. If you find this difficult to do, do not worry; we will explore these questions further during your session

Please print or write clearly.

Please bring these questions and answers to your initial homeopathic consultation. If you need more space to answer these questions, feel free to answer on a separate piece of paper.

1. What would you like homeopathy to do for your child?

2. What are their physical complaints?

3. What are their emotional / mental complaints?

4. What are their behavioral complaints?

5. When did their health problems start?

6. Which health complaint is the most important to your child?
7. Which health complaint is the most important to you?
8. Which health complaint is the most important to the educational system?

9. In general, does your child run on the chilly side or the hot side or somewhere in between? Chilly children often complain about how cold it is and like lots of socks and sweaters. Warm children often complain about how hot it is and like to take off as much of their clothes as they can as often as they can.

10. Does a particular part of their body get especially hot or cold at any time of the day or night? Or in special circumstances?

11. In general, do you notice if your child is sensitive to or strongly affected by the various seasons of the year? Or the change of seasons?

12. Are they sensitive to or strongly affect by any weather or climate condition including: hot weather, cold winds, wet days, sun exposure, cloudy days, fog, snow, cool breezes etc.?

13. Is there a natural environment that your child prefers or feels relief from? Do the mountains, the desert, the seashore affect them?

14. Are they affected by open air or drafts of air or stuffy rooms? In what way?

15. What times of day does your child feel most energetic?

16. What times of day do they feel most tired? How can you tell? What do they do or say?

17. What time of day are their symptoms most troublesome?

18. What kind of exercise or activities do they enjoy participating in? *For example: walking, hiking, horseback riding, bike riding, go cart racing, winter sports, summer sports, yoga, parties, dancing, singing.?* Do they feel better or worse from physical exertion or exercising?

19. Do they perspire? Do they perspire on a particular part of their body? Do they perspire most at a particular time of day or in a particular situation?

20. Do snug fitting clothing, such as shoes, turtlenecks, watchbands, waistbands, bras, pantyhose, or even rings on the fingers, bother them?

21. Are they bothered by noises, like chalk on a chalkboard or people chewing?

22. Are they bothered by light, like fluorescent lighting or car headlights or sunlight?

23. Are they bothered by odors, like perfume, gasoline, cleaning chemicals, room deodorizers or even flowers or essential oils?

24. Do they have any specific fears? *For example: speaking up, taking tests, bugs, spiders, dogs, the dark, intruders, other animals, standing at a tall place looking down, being alone, being in an elevator, flying, in or on water etc.*

25. What are they drawn to? *For example: machines, people, animals, plants, rocks/minerals, butterflys, community activities, water, mountains etc.* Do they have hobbies? Do they have any collections of things?

26. Do they have any problems with sleep?

27. What is their favorite sleep position? Is there a sleep position that is uncomfortable for them?

28. Do they now or in the past, talk, laugh, cry, moan, snore, scream, walk, jerk, or grind or clench their teeth in their sleep?

29. Do they suffer from restless legs in bed or leg cramps or growing pains?

30. Do they uncover any part of their body during sleep or do they like to be well covered?

31. Do they remember their dreams? Are there themes to their dreams? Do they have recurring dreams?

32. In general, do they wake up feeling refreshed in the morning?

33. What is their mood upon waking in the morning?

34. When do they get to bed at night? When do they get to sleep? When do they wake up? Do they resist going to sleep? Do you know why? Do they resist waking up?

35. What do they eat on an average day for breakfast? Does your child eat breakfast?

36. What do they eat on an average day for lunch?

37. What do they eat on an average day for supper?

38. What do they eat for snacks? And when?

39. How thirsty is your child? What do they like to drink? Do they prefer to use ice in their drinks?

40. What foods do they crave or love? What do they eat for pleasure?

41. What foods do they strongly dislike?

42. What foods cause symptoms when your child eats them? What reaction do you notice in your child?

43. Please **rate** the following, **10** being something your child loves. These could be foods you prohibit but they still love. Here are some food and drink suggestions; feel free to add your favorites.

Tastes &
Textures:

sweet
sour
salty
spicy
smoked
bitter
crunchy
creamy
slippery

Temperature:

hot food
cold foods
hot drinks
cold drinks
ice

Drinks:

alcohol
coffee
tea
soda
juice
sparkling water

_____
_____

Foods:

meat
fat on meat
fish
chicken
shellfish
pork
bacon
milk
cheese
yogurt
ice cream
butter
eggs
_____
_____
_____
_____
_____
_____
_____

chocolate
bread
pasta
cakes
pastries
nuts
pickles
fruit
lemons
oranges
raw veggies
cooked veggies
salads
onions
olives
garlic

Peculiar things:

sand
dirt
clay
chalk
coffee beans
paste

44. Please attach or include your child's complete vaccination record, if possible.

45. What medications and/or supplements does your child receive and what are they for?
    Please list:

    a. Medication name: for what condition:

    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____

    b. Supplement name and **ingredients**: for what condition:

    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____