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

Please answer as many of the following questions as you can, 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. I will help you tell me the story of your condition.

Please print or write as clearly as you can.

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 you?

2. What are your physical complaints?

3. What are your emotional and/or mental complaints?

4. When did your health problems start?

5. What health complaint is the most important to you?

6. In general, are you a chilly person or a hot person? Or somewhere in between? *Chilly people often feel cold and carry warm clothing with them should they get a chill. Warmer people often feel uncomfortable in a warm room or in hot weather and may wear less clothing than others all year round.*

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

8. In general, are you sensitive to or strongly affected by the various seasons of the year? Or the change of seasons?

9. Are you 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.?

10. Is there a natural environment that you prefer or feel relief from? Do the mountains, the desert, the seashore affect you?

11. Are you affected by open air or drafts of air or stuffy rooms? In what way?

12. What times of day do you feel most energetic?

13. What times of day do you feel most tired?

14. What time of day are your symptoms most troublesome?

15. What kind of exercise or activities do you enjoy participating in*? For example: walking, hiking, horseback riding, car racing, winter sports, summer sports, yoga, parties, dancing, meditation, chanting etc.?* Do you feel better or worse from physical exertion or exercising?

16. Do you perspire? Do you perspire on a particular part of your body? Do you perspire most at a particular time of day or in a particular situation?

17. Does snug fitting clothing, such as turtlenecks, watchbands, waistbands, bras, pantyhose, or even rings on the fingers, bother you?

18. Are you bothered by noises, like chalk on a chalkboard or people chewing?

19. Are you bothered by light, like fluorescent lighting or car headlights or sunlight?

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

21. Do you have any specific fears? *For example: speaking to a group, taking tests, bugs, spiders, dogs, other animals, standing at a tall place looking down, being alone, being in an elevator, flying, in or on water etc.*

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

23. Do you have any problems with sleep?

24. What is your favorite sleep position? Is there a sleep position that is uncomfortable for you?

25. Do you now or in the past, talk, laugh, cry, moan, snore, scream, walk, jerk, or grind or clench your teeth in your sleep?

26. Do you suffer from restless legs in bed or leg cramps?

27. Do you uncover any part of your body during sleep or do you like to be well covered?

28. Do you remember your dreams? Are there themes to your dreams? Do you have recurring dreams?

29. In general, do you wake up feeling refreshed in the morning?

30. What is your mood upon waking in the morning?

31. When do you get to bed at night? When do you get to sleep? When do you wake up?

32. What do you eat on an average day for breakfast? Do you eat breakfast?

33. What do you eat on an average day for lunch?

34. What do you eat on an average day for supper?

35. What do you eat for snacks? And when?

36. How thirsty are you? What do you like to drink? Do you use ice in your drinks?

37. What foods do you crave or love? What do you eat for pleasure?

38. What foods do you strongly dislike?

39. What foods cause symptoms when you eat them? What reaction do you have?

40. Please **rate** the following foods and tastes, **10** being something you 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

41. What medications and/or supplements are you taking and what are they for? Please list:

    a. Medication name: for what condition:

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    b. Supplement name and ingredients: for what condition:

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

For Women:

Regardless of whether you are postmenopausal or post hysterectomy, please answer the following questions with as much detail as you can.

42. At what age did you begin to menstruate? Did you have any trouble or symptoms at that time?

43. Do you have any symptoms in the weeks before your menstrual flow? *This might include changes in mood, energy, appetite, sleep, breast tenderness, sex drive and overall fluid retention etc.* If you no longer menstruate, how was the premenstrual time in the past?

44. Are your menstrual cycles regular? From day 1 of your menstrual flow to day 1 of your next menstrual flow, how long is your cycle? If you no longer menstruate, how regular was your cycle in the past?

45. How many days does your menstrual flow last? If you no longer menstruate, how long did your flow last in the past?

46. Would you estimate that your menstrual flow is heavy or average or light? If you no longer menstruate, how heavy was the flow in the past?

47. Do you have any pain during your menstrual flow?

48. Do you have any other problems during your menstrual flow? If you no longer menstruate, how was your menses in the past?

49. What form of birth control do you use, if any? If you have used Birth Control pills or injections or IUDs or barrier methods, when did you use them? For how many years? Did you experience any side effects?

50. If you are now menopausal, what was the date of your last menstrual period?

51. Are you now or have you in the past, had any problems during peri-menopause or postmenopausal?

52. Have you been pregnant? Have you given birth? Have you had any miscarriages? Have you had any abortions?

53. If you have ever been pregnant, how were your pregnancies? Any difficulties or traumas or complications?

54. If you have had children, did you breastfeed them? Any difficulties?

55. Any problems with your breasts? Any lumps, cysts, inverter or retracted nipples, milk discharge, other discharge, PMS tenderness?

56. Any excess body hair, such as facial bearding, excess pubic hair, pubic hair extending to the navel, hair between the breasts etc.?