

CLIENT QUESTIONNAIRE

Name:			
Address:			
Home Phone: ()		Work Phone: ()	
A personal & confidential message may be left at this phone no. ()			
Marital Status (circle one): S M Part. D W Sep. Number of Children:			
Age:	Date of Birth:	Height:	Weight:
Occupation (adult):			
Referred By:			
If Child, Parent's/Guardian's Name:			

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

COMPLAINT	SINCE	CAUSES

ARE YOU CURRENTLY TAKING ANY MEDICATION? PLEASE LIST (USE ADDITIONAL PAPER IF NEEDED)

MEDICATION/SUPPLEMENTS	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT OR REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

<input type="checkbox"/>	Abscesses	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Herpes Genitalia	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Amnesia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Pelvic Inflammatory Disease	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>		Peritonitis	Strep Throat	<input type="checkbox"/>	Warts
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Sunstroke	<input type="checkbox"/>	Worms
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Prostatitis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Yellow Fever
<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Any other major conditions? _____
 Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? _____
 What operations have you had and when? Any complications? _____

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECT

Age of first menses: _____ Number of Pregnancies: _____

What vaccinations have you had? _____

Any adverse effects? _____

Have you lost any weight lately? How many pounds? _____

What exercise do you do and how much? _____

How much of the following substances are you using:
 Tobacco: _____ Alcohol: _____ Coffee: _____ Recreational Drugs: _____

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR AILMENTS HAVE AFFECTED YOUR RELATIVES:

Alcoholism		Asthma		Diabetes		Gout		Insanity		Skin Diseases	
Allergies		Cancer		Epilepsy		Hay Fever		Paralysis		Syphilis	
Arthritis		Depression		Gonorrhea		Heart Disease		Pneumonia		Tuberculosis	
RELATIVE		AGE IF ALIVE	AGE AT DEATH	AILMENTS							
Mother											
Father											
Brothers											
Sisters											
Children											
Maternal Grandmother											
Maternal Grandfather											
Maternal Aunts/Uncles											
Paternal Grandmother											
Paternal Grandfather											
Paternal Aunts/Uncles											
Other											

Are you currently under the care of another physician(s)? For what condition? What has your treatment been? _____

Have you used homeopathy before? When and for what conditions? _____

FOR THE FOLLOWING LIST OF FOODS, INDICATE WHICH YOU REALLY LIKE, DISLIKE STRONGLY OR WHICH YOU CANNOT EAT:

WRITE NO. 1 TO 3 BESIDE THE FOODS YOU LIKE (3 BEING THE STRONGEST)
 CIRCLE 1-3 TIMES FOR FOODS YOU DISLIKE
 WRITE AN "X" THROUGH FOODS YOU CAN NOT EAT, ADD ANY FOODS NOT LISTED

SWEETS	CHOCOLATE	SALTY FOODS	SPICY FOODS	EGGS		
SOUR FOODS: VINEGAR ____, DRESSINGS ____, PICKLES ____						
DAIRY PRODUCTS: CREAM ____, BUTTER ____, CHEESE ____, ICE CREAM ____, MILK ____, YOGURT ____						
MEAT: PORK ____, BEEF ____, CHICKEN ____, FAT ON MEAT ____						
RICH FOODS: CREAM SAUCES						
TEA	COFFEE	BEER	WINE	SPIRITS	COLD DRINKS	WARM DRINKS
FRUIT:						
VEGETABLES:						
ANY OTHER FOOD OR DRINK:						

What type of weather do you like and dislike? Why? _____

What things give you the most pleasure in life? _____

What things give you the most displeasure? Why? _____

List any fears and phobias you may have: _____

Do you sleep well? If not, why? _____

List any characteristic dreams you have now or had in the past. Include dreams which are/were vivid, recurrent or seemed important to you. _____

Any additional comments; _____

Emergency Contact:

Name:	
Address:	
Home Phone: ()	Work Phone: ()
Relationship	

Physician Information:

Name:
Address:
Phone: ()
<input type="checkbox"/> Please send a report of each visit sent to my doctor.

Signature of Client: _____ date: _____

Signature of Parent or Guardian if client is a minor: _____ date: _____