Sorelle Homeopathy
integrative natural medicine

CONFIDENTIAL

HOMEOPATHIC ADULT PATIENT HISTORY QUESTIONNAIRE

You have come here to get well. In order to do that I depend on your co-operation. HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE ME. If I am to make a successful prescription, I must know all the details of your sickness. I need to also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental-emotional make-up.

This information enables me to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order to find out all about you, I shall be asking you many questions. Each one of these questions has a definite meaning and significance for me. There is not a single question that is useless. Even something that you may think is not connected with your trouble, may be the most important factor in deciding the correct Homeopathic medicine.

To provide the most appropriate treatment possible, please take the time to complete the information on this questionnaire carefully and completely. Any information you provide will be treated with complete confidentiality as per Australian National Privacy Laws and not used for any purpose other
than those stated in this form.

I understand that:

- This is not a medical practice.
- Initial Homeopathic consultations/treatments may take up to 90 minutes to complete.
- The physical examination I receive may involve partial undressing and / or palpation of the complaint, if applicable.
- I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this clinic of any changes in my health.
- I understand that payment is expected at end of each consultation. A full consultation fee can be charged in the event that the appointment is changed or cancelled by you without 24 hours notice.

Signature…… Date……..

New Client Information

Dr. / Mr. / Mrs. / Ms. / Miss. / Master / Other……..

Given Name…….. Surname…….....

Preferred Name…….....

Address…….....

…… Post Code…….....

Phone (BH)…… Phone (AH)…….....

Phone (mobile)…… Email……

Birth Date…….. Occupation…….....

Emergency Contact…….. Phone…….....

Usual Medical Doctor / Health Care Provider…….....

Address…….....

…….. Phone…….....

Referred by (please circle):

Family Friend Other……

Have you ever been treated by a Homeopath before? Yes No

Do you have Private Health Insurance? Yes No

If so, please provide name of health fund….....

Do you have a Health Care Card / Pension / Student Card? Yes No

Card Number…….. Expiry Date……

Please note the following when filling out this questionaire, the following statements are practically useless to a Homeopath:

- **I'm sick**
- **I have a virus**
- **I have a headache**
- **I have a sore throat**
- **I don't feel well**
- **I'm depressed**
- **What do you have for an upset stomach?**
- **I have a pain here, here, and here**
- **Do you have anything for a cold?**
- **I have anxiety attacks**
- **I have a fever**
- **Here are my blood test results**

People are used to dealing with "regular" doctors, and don't know how to give their symptoms to a homeopath. I do not have a single remedy for "headache", or "cold" or any other diagnosis. I can only come up with a remedy after hearing the WHOLE case as uniquely experienced by you and only you!

HISTORY OF CURRENT COMPLAINT / PROBLEM

1. What are your main health issues concerning you today?

……
……
……

2. List your current symptoms and any factors which make them better or worse (eg. rest, activity, foods, temperature, weather etc.)

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3. Aetiology–this means the CAUSE of the complaint. What caused you to get sick? Think about what was going on at, or around, the time of the occurrence? The answer may be obvious if you were stung by a bee or fell out of a tree; but, less obvious aetiologies would include things like change of weather, suppressing feelings or suppressing symptoms with drugs, over-studying, receiving good news or bad news, having to put up with rudeness, loss of vital fluids–from diarrhoea, bleeding, excessive sex, etc.; loss of a loved one, loss of property, jealousy, fright, use of drugs–prescription or otherwise–never recovering completely from an infection like the flu or other illness, suppressing a fever with anti-fever medication, loss of sleep, surgery, too much alcohol, too much junk food, getting the feet wet, drinking cold water on a hot day, embarrassment, breathing in dust, over-exertion, exposure to toxins, vaccinations, etc.

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4. Please list all conventional and complementary medical treatments you have tried so far for this issue. Please rate them on a scale of 1 (low efficiency) to 5 (high efficiency).

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5. Do you have any additional health issues? (Please list).

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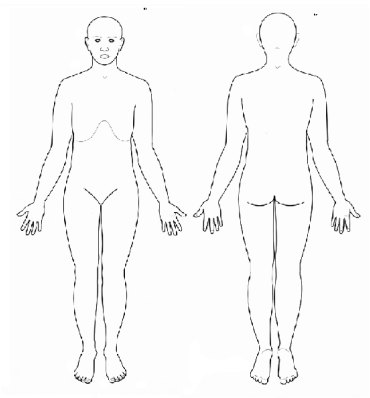
CURRENT MEDICINES / SUPPLEMENTS / HERBS

Name of Medicine	Dosage per day	Since when	Reason for taking

6. If applicable, please mark area (s) in the figure below, the locations of your trouble and write the exact sensation or type of pain you experience at those spots.

Front Back



7. Modalities – This is a fancy word that means, what makes your complaint better or worse? Please don't say "nothing!". THINK! This question is very important to us. Consider the following possibilities: Better or worse from hot or cold applications, weather, bathing/showering, warm rooms, fresh air, drafts, motion, sleep, a certain time of day, massage, hard pressure, assuming a certain position; stimuli (conversation, noise, light, touch, rubbing, music, company, consolation, sympathy, etc.), eating, drinking, ice, hot tea, milk, sweets, chocolate, etc. Remember, these are only examples. Think about your case: what makes you feel somewhat better? What makes you feel worse? Another way of thinking about this is saying, What does the complaint *force* you to do? For example, if you're doubled over in pain, then you are better for bending double. If you hold your chest when you cough, then you're better for pressure.

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PATIENT GENERAL HEALTH INFORMATION

8. Do you have? Please rate all of the following on a 1 to 5 scale. (1 is for low severity and 5 is for high severity).

Allergies / sensitivities to Drugs (eg. Penicillin) ……
Foods ……
Environmental (eg. pollens or dust) ……

DIGESTIVE SYMPTOMS

Pain ……
Bloating ……
Indigestion ……
Diarrhoea ……
Constipation ……
Wind ……

FOODS

What foods do you crave? ……
When? ……
What foods do you severely dislike? ……

SLEEP PROBLEMS

Difficulty getting to sleep? ……
Waking during sleep? ……
How do you feel on waking? ……

SYMPTOMS IN OTHER AREAS (Please circle anything current)

9. Head / Eyes / Ears / Nose / Teeth / Chest / Urinary Tract / Menstrual / Reproduction / Skin / Skeletal

10. Do you have currently or in the past (please circle): Eczema Asthma Hay fever

BODY TEMPERATURE

11. Do you….prefer to be (please circle): Cool Cold Warm Hot

12. What is your favourite weather and why? ……..
13. Do you perspire? ……Where? ……

ENERGY LEVELS ON SCALE OF 1 TO 10 (With 1 being low and 10 being very high)

1 2 3 4 5 6 7 8 9 10

MORE ABOUT YOU

Fears or phobias? ……..
Smoking (how many per day?) ……
Alcohol (how much per week)? ……
Recreational drugs (which & when) ……

YOUR MEDICAL HISTORY

Birth / Infant:

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……
……

Your mother's health during pregnancy?
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Did you experience any birth trauma?
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Breastfed? Yes No How Long? ……

CHILDHOOD
Did you receive any childhood vaccinations? Yes No
Did you have any childhood vaccination reactions? ……
Recurring infections? Yes No Where? ……
Approximate number of courses of antibiotics taken in total? ……

PLEASE GIVE DETAILS OF ANY ADDITIONAL HEALTH ISSUES YOU HAVE HAD (Including Operations, Viruses, Injures):

0-5 years ……
5-10 years ……
10-15 years ……
15-20 years ……
20-30 years ……
30-40 years ……
40-50 years ……
50-60 years ……
60 + years ……

FAMILY MEDICAL HISTORY

Please list known diseases of family members (skin problems, heart disease, high blood pressure, cancer, diabetes, mental illness, other)

Mother ……
Father ……
Maternal Grandmother ……
Maternal Grandfather ……
Paternal Grandmother ……
Paternal Grandfather ……
Sister/s ……
Brother/s ……

DESIRED OUTCOME FOR YOUR TREATMENT

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ANYTHING ELSE YOU WANT ME TO KNOW

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