



Health Review Form (Acute)

Please write or print clearly. Your information will remain confidential between you and your Homeopath.

Full Name: _____

Full Address: _____

Email: _____ Phone: _____

Age: _____ Height: _____ Date of Birth: _____ Gender: _____

Place of Birth: _____

Have you had an organ transplant?

Peacemaker?

Pregnant?

Breastfeeding?

Reason for the consultation:

Current Symptoms:

When did the symptoms begin?

Can you suggest some factors that helped create these symptoms?
(Fright or shock, cold exposure, overwork, flu etc.)

Any particular sensations associated with the symptom?

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If you have a Headache, what is the trigger, location and sensation?
(Pounding, throbbing, left side, sinus, stress, hormones, lack of sleep etc.)

If you have a Migraine, what is the trigger, location and sensation? (Pounding, tearing, light sensitivity, right eye, stress, hormones, better dark room etc.)

If you have a cough, please describe: (tick any relevant boxes and describe below)

- | | | |
|---|---|--|
| <input type="checkbox"/> Barking Cough | <input type="checkbox"/> Asthmatic Cough | <input type="checkbox"/> Suffocative Cough |
| <input type="checkbox"/> Dry cough | <input type="checkbox"/> Dry Tickling cough | <input type="checkbox"/> Rattling Cough |
| <input type="checkbox"/> Cough Worse at Night | <input type="checkbox"/> Cough with blood | <input type="checkbox"/> Cough difficult expectoration |
| <input type="checkbox"/> Cough with dry Air Passages | <input type="checkbox"/> Spasmodic cough | <input type="checkbox"/> Cough with post nasal drip |
| <input type="checkbox"/> Cough with Acidity | <input type="checkbox"/> Dry cough with sore chest | <input type="checkbox"/> Cough with white phlegm |
| <input type="checkbox"/> Cough with yellow-green phlegm | <input type="checkbox"/> Cough with oppressed sensation | <input type="checkbox"/> Cough with fever |
| <input type="checkbox"/> Exhausting dry cough | <input type="checkbox"/> Gagging choking cough | <input type="checkbox"/> Cough with fever |
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If you have mucus, please describe: (tick any relevant boxes and describe below)

- | | | | | |
|---|--|---------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Green | <input type="checkbox"/> Yellow | <input type="checkbox"/> Green-Yellow | <input type="checkbox"/> White | <input type="checkbox"/> Clear |
| <input type="checkbox"/> Salty Taste | <input type="checkbox"/> Thick | <input type="checkbox"/> Thin | <input type="checkbox"/> Watery | <input type="checkbox"/> Constant Stringy |
| <input type="checkbox"/> Blocked nose | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Burning | <input type="checkbox"/> Mucus | <input type="checkbox"/> Post nasal drip |
| <input type="checkbox"/> Hawking of mucus | <input type="checkbox"/> Mucus stuck in throat | | | |
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Sore Throat? (tick any relevant boxes and describe below)

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Left sided | <input type="checkbox"/> Right sided | <input type="checkbox"/> Splinter like feeling |
| <input type="checkbox"/> Dry Throat | <input type="checkbox"/> White pus | <input type="checkbox"/> Tonsils Red Purple |
| <input type="checkbox"/> Red | <input type="checkbox"/> Red & Shiny | <input type="checkbox"/> Extending to the ears |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Dry & Burning | <input type="checkbox"/> Tonsils swollen |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Red, Raw & Burning | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Swollen | <input type="checkbox"/> Lump sensation in the throat | <input type="checkbox"/> Hair in back of throat |
| <input type="checkbox"/> Inflamed | <input type="checkbox"/> Better Cold drinks | <input type="checkbox"/> Better Warm drinks |
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Thirst: (tick any relevant boxes and describe below)

- | | | |
|--|---|---|
| <input type="checkbox"/> I am thirsty for small sips | <input type="checkbox"/> I am thirsty for big gulps | <input type="checkbox"/> I have no Thirst |
| <input type="checkbox"/> Fear of drinking hot | <input type="checkbox"/> Nausea after drinking | <input type="checkbox"/> Better warm drinks |
| <input type="checkbox"/> Better cold drinks | | |
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Describe anything that you feel is associated with the current symptoms that is unusual, rare and/or peculiar.

At what time during the day or night do you feel worst?

What position are you most comfortable in? (Sitting / Standing / Lying etc)

What about your appetite?

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Please describe anything else that you feel is associated with the current issues?

Does this symptom shift from one place in your body to another?

Related symptoms elsewhere in the body?

Does anything make the complaint better or worse? (rest, movement, heat, cold, massage, pressure, stormy/rainy weather, sun, seasons, etc.)

Do you have any of the following symptoms:

(tick any relevant boxes and describe below)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Vomiting & Diarrhoea | <input type="checkbox"/> Cold all over | <input type="checkbox"/> Feel Hot |
| <input type="checkbox"/> Want to be left alone | <input type="checkbox"/> Body aches | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Want windows closed | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Worse warm rooms | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Weepy |
| <input type="checkbox"/> Worse form any movement | <input type="checkbox"/> Better resting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Need the window open | <input type="checkbox"/> Metallic taste | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Aching all over | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Deep bone pain | <input type="checkbox"/> Need fresh air | <input type="checkbox"/> As if drunk |
| <input type="checkbox"/> Feel separated or scattered | <input type="checkbox"/> Spitting blood | <input type="checkbox"/> Chilliness |
| <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Drained, Dull & Dizzy | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Dry Mouth Dizzy | <input type="checkbox"/> Need company | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> Excess sweating | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Can't breathe cold air | <input type="checkbox"/> Better Movement | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Earache |
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