Health Review Form (Chronic)

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: ______________ Place of Birth: ______________

Current Weight: ___________ Weight 1 Months ago: ___________ Are you on Medications? ___________

☐ Have you had an organ transplant? ☐ Peacemaker? ☐ Pregnant? ☐ Breasfeeding?

Occupation: ______________ How many hours do you work per week? ______________

Do you have any allergies? (Medication, Food etc) ______________________________

____

What conditions are you currently under a physician's care for? ______________________________

____

What are your most important health issues? (list in order of importance)

1. ______________________________

Since: ______________ Causes: ______________________________

2. ______________________________

Since: ______________ Causes: ______________________________

3. ______________________________

Since: ______________ Causes: ______________________________

4. ______________________________

Since: ______________ Causes: ______________________________

____

How is your Sleep? ______________________________

Describe your energy Level? ______________________________

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

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

Are you affected in any way by different kinds of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by the seashore.

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

Have you ever had a head injury? If so, when? (please describe)

Is there an incident, medication or other event in your life you have never felt well since?

Have you had any other Health problems in the past?

Did your mother have any problem(s) during pregnancy?

Was there any difficulty with your birth? If so, provide details.

Are your periods regular? How many days is your flow? How frequent?

Are your periods painful or symptomatic? If so, please explain:

What is your birth control history?

Do you experience yeast infections or urinary tract infections? If so, please explain:

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Would you describe yourself as?

☐ Anxious ☐ Jealous ☐ Doubtful ☐ Suspicious ☐ Like being alone

☐ Impatient ☐ Depressed ☐ Angry ☐ Irritated ☐ Prefer being with others

☐ Thunder ☐ Animals ☐ Tendency to rush

Other: (please describe) ____________________

Do you experience any digestive issues or problems with bowel movements?

How would you describe your emotional state, including any stress or anxiety levels?

Family Health History (Please list any concerns)

Any Adverse reactions?

Are you fearful of?

☐ Dogs ☐ Dark ☐ Death ☐ Robbers

☐ Sudden noises ☐ The Future ☐ People ☐ Poverty

Other: (please describe) ____________________

Dreams or Nightmares? If yes (please describe)

What other therapies or treatments are you presently taking?

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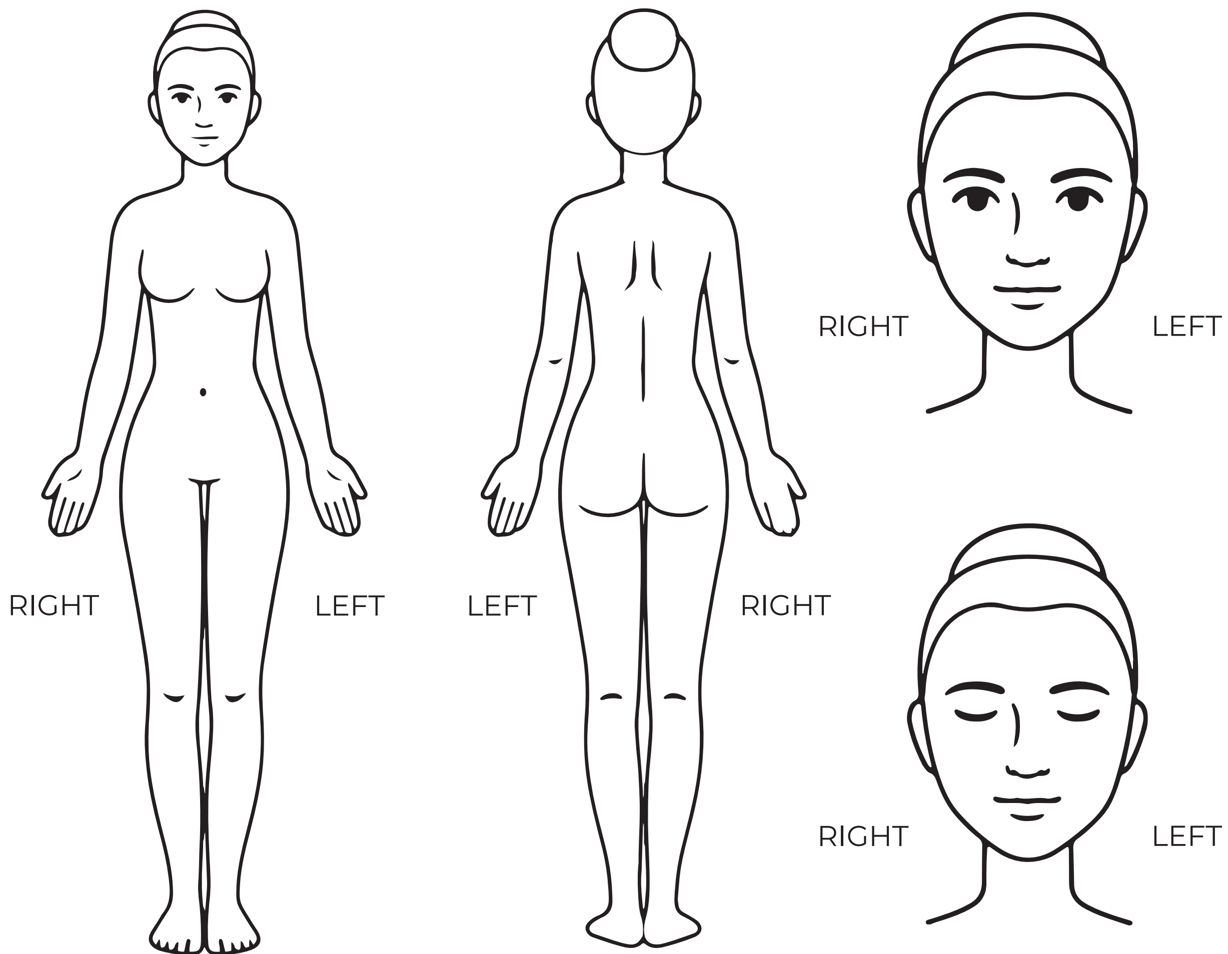
Describe any pain below:

☐ Sharp	☐ Burning	☐ Radiating	☐ Itchy	☐ Drawing	☐ Deep bone
☐ Throbbing	☐ Severe	☐ Stinging	☐ Mild	☐ Pulsing	☐ Hit by truck
☐ Electrical	☐ Pounding	☐ Intermittent	☐ Crushing	☐ Sharp	☐ Can't breathe
☐ Hot	☐ Constant	☐ Aching	☐ Cramping	☐ Sore	☐ Numbness
☐ Squeezing	☐ Stabbing	☐ Cutting	☐ Ache all over	☐ Stiff	☐ Travelling
☐ Dull	☐ Tight	☐ Tugging	☐ Throbbing	☐ Spasm	☐ Throbbing

☐ Bent over, can't stand up

Other Pain type? ______________________

Please indicate on the drawing where the pain is located below:



What makes the pain or other ailment better? ______________________

____

What makes the pain or other ailment worse? ______________________

____

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Do you suffer from any Vertigo? if yes (please describe)

What are your health goals?

Is there anything else you would like to add?