Health Thyme
TRANSFORM YOUR HEALTH

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.

What other therapies or treatments are you presently taking?

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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? (Vaccines, Flu shots etc.)

_____

_____

Are you fearful of?

- [ ] Dogs
- [ ] Dark
- [ ] Death
- [ ] Robbers
- [ ] Sudden noises
- [ ] The Future
- [ ] People
- [ ] Poverty

Other: (please describe) _____

Dreams or Nightmares? If yes (please describe)

_____

_____

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

_____

_____

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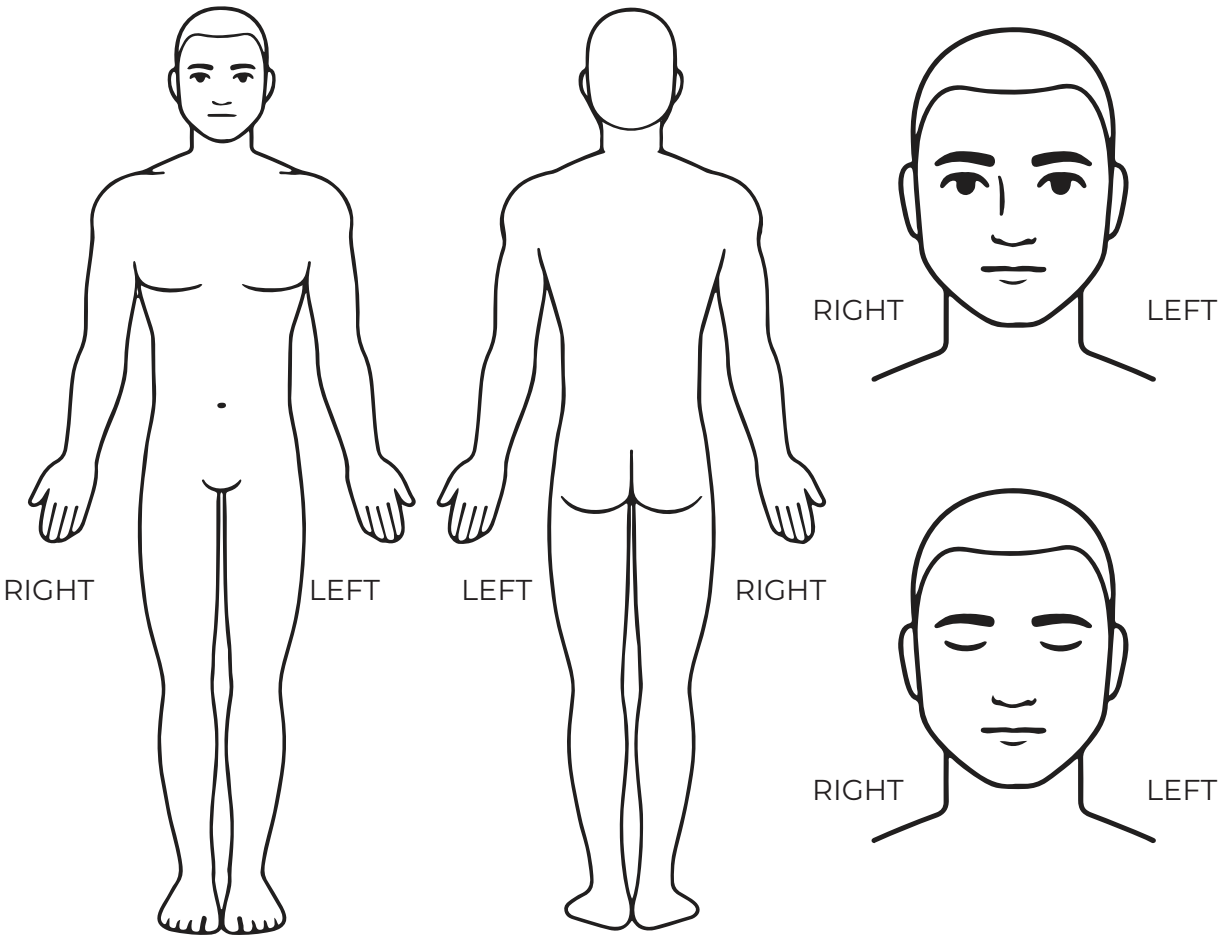
Describe any pain below:

☐ 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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What are your health goals?

Is there anything else you would like to add?