PLEASE READ BEFORE FILLING OUT THIS INTAKE FORM.

Your homeopathic remedy is mainly selected on the information you provide about yourself and your chief complaint(s). In order to make a successful remedy choice it is extremely important to understand the details of the symptoms you experience. I must also learn all the attributes that belong to you as a unique individual, and this includes your reactions to various factors, your past and family history, your relationships and your personality.

To gain this information you will be asked many questions. Each one is significant to a homeopath, and often something you may think has no connection with your symptoms may be the most significant information used to select the correct homeopathic remedy for you. For example, to tell a homeopath "I have a headache", "the flu", "a rash", would not be enough information; a better way is to describe your symptoms in as much detail as possible such as "I have a throbbing headache behind my left eye that gets worse late in the afternoon and from hot drinks and better from putting a cool cloth on my forehead – my eyes get large and red, I feel nauseous and sometimes I feel like the top of my head will burst open". Use extra paper if necessary! You can use the following outline of things to include in your descriptions:

LOCATION: Please give the exact location of the complaint, as well as where the pain or sensation may spread or extend to.

SENSATION: Express the type of sensation or pain that you get in your own words however simple or funny it may seem. You may feel a mouse running up your leg, an iron band around your head or pain that is stabbing, cutting, burning, etc; just express it exactly as it feels to you!

WHAT MAKES YOU FEEL WORSE OR BETTER: Many factors will likely influence your complaint(s) – some will cause the symptoms to increase and some to decrease. Think about how your symptoms are affected by things like weather, heat, cold, talking, laughing, sleeping, lying, sitting, standing, walking, eating, drinking, etc.

DISCHARGES: The body can have discharges from things like ulcers, fistulas, abscesses, eruptions and discharges can occur in all different parts of the body, like your skin, lungs, eyes, nose, ears, mouth, vagina, etc. Please describe any discharges you may have based on the following:

- The quantity & time or condition under which it occurs or changes
- The consistency – thin, thick, stringy, clotted, etc.
- Is it like jelly, the white of an egg, watery, sticky, forms a scab, etc.
- The odor, what does it remind you of?
- Does it irritate the area, and if so, in what way?

THIS QUESTIONNAIRE IS ORGANIZED INTO THREE MAIN SECTIONS:

1. Information about your chief complaint(s)
2. General information about who you are, your family history and how your body works
3. A timeline of the events in your life (beginning with your mother's pregnancy with you and your birth)

Please be sure to read over each section and question carefully; think deeply about it, and if necessary, consult someone close to you and then answer fully and completely. Describe everything freely and frankly without hesitation. REMEMBER THAT WHATEVER YOU WRITE REMAINS ABSOLUTELY CONFIDENTIAL. Your honesty and co-operation is extremely important to the process of choosing the appropriate homeopathic remedy to enhance your health. Most of us do not get the luxury of looking so deeply into ourselves, so relax and allow it to be an enriching experience.

Full Name (first, middle, last, maiden): **DOB:** **Place of Birth:**

Home Phone: **Work Phone:**

Cell Phone: **Email:**

Mailing Address:

Emergency Contact Person: **Phone:**

Referred By:

Thank you for taking the time to complete this holistic intake! All information on this form is completely confidential.

A) Issue(s) you would like to see homeopathy address or balance at this visit: (please provide as much detail as possible)

B) Please describe those things that make your particular complaint(s), or you as a whole, feel better or worse.

1) *Time Modalities: (please give exact times ie. 3pm, or time periods ie. midnight – 4am)*
   - Is there a time of day you tend to feel best overall (mentally, emotionally, physically and energy-wise)?
   - Is there a time of day you tend to feel worst overall (mentally, emotionally, physically and energy-wise)?
   - Is there a time of day your complaints tend to get better, or resolve?
   - Is there a time of day your complaints tend to start, or get worse?
   - Do your complaints tend to recur at specific intervals (at the same time each day, week month, or year)?

2) *Temperature Modalities: (please be as detailed as you can)*
   - Do you have a preference for or dislike of hot or cold weather? If so, why?
   - Do have a preference for or dislike of damp or humid weather? If so, why?
   - Do you have a preference for or dislike of certain seasons (Spring, Summer, Winter, Fall)? If so, why?
   - Do you have a preference for of dislike of certain types of weather (rain, snow, sun, moon, wind, thunderstorms)? If so, why?

- Do any of your specific complaints get better or worse from any of the above temperature modalities? If so, please describe.

3) *Positional Modalities: (please describe the exact position that makes you feel better or worse)*

- Do experience relief or discomfort when standing, sitting, bending, stooping, lying on your back or side, or in any other position? If so, please describe.

- Do any of your specific complaints get better or worse in particular positions? If so, please describe.

4) *Food & Drink Modalities: (please be specific about what and when these things make you feel better or worse)*

- How often do you get hungry, how much do you tend to eat, and how easily do you feel full, or not?

- In general do you feel better or worse either before, during or after eating? If so, please specify when.

- What foods do you prefer to eat (either specific foods, or groupings like salty, sour, spicy, sweet, etc)?

- What foods do you avoid eating or dislike, and why?

- Are there any foods you are allergic to? If so, what happens when you eat them?

- Do you tend to be thirsty or not? How much do you drink in a day?

- Do you prefer your drinks hot, room temp, cold, or with ice?

- Do you tend to sip at a drink all day, or chug it down all at once? Why?

- What types of products do you prefer to drink (juice, water, coffee, tea, alcohol, soda, diet or regular, etc)?

- Any drinks you are allergic to? If so, what happens when you drink them?

- Do any of your specific complaints get better or worse when eating or drinking? If so, please describe.

- Do you suffer from any addictions (food, smoking, alcohol, drugs, etc). If so, please describe, including any treatment.

5) *Environmental Modalities: (please be as specific as you can about exactly what makes you feel better or worse)*

- Are you sensitive to noise, smells, bright lights, crowds, medications, electromagnetic frequencies (EMF), etc? If so, please describe exactly what causes, environments or situations you react to, and what your reaction is?

- Do you feel better or worse from hot or cold applications, bathing, stuffy rooms, etc? If so, please explain.

- Do you tend to startle easily? If so, what commonly causes you to startle?

- Do any of your specific complaints get better or worse in certain types of environments? If so, please explain.

C) General Overall Characteristics: (please be as descriptive as you can)

1) *Sleep Patterns:*

- What time do you typically fall asleep, and how long does it normally take you to fall asleep?

- What time do you normally wake up, and how do feel on awakening (refreshed, tired, groggy, etc)?

- Do you tend to wake up during the night? If so, what time or time period, and what wakes you up?

- Do you do anything during sleep (snore, talk, laugh, cry, yell, kick, hit, walk, cough, etc)? If so, please describe.

- Do you have any dream patterns (pleasant, unpleasant, frightening, violent, premonitions, vivid, recurring themes)?

2) *Mental Patterns:*

- Do you have any memory issues? If so, please describe (short term memory issues, long term, names, numbers, etc).

- Are you easily distracted or confused? If so, please describe the situations when this occurs.

- Does your mind feel sharp, or dull? Do you have lots of thoughts, do you feel mentally slow, or do you get easily overwhelmed by too much mental information/stimulation ? If so, please explain.

- Do you have any obsessions or compulsions (to clean, wash hands, re-check things, etc)? If so, please describe.

- Do you suffer from a brain injury, or have you ever had a concussion, seizure, stroke, head injury or been in a coma? If so, please describe, including dates of injury, causation, severity & any permanent damage or deficit.

3) *Emotional Patterns: (please give as much detail about your unique emotional expression & personality as you can)*

- What do you tend to feel stressed by or about on a regular basis? Please describe.

- Do you have any fears, phobias or do you tend to feel anxious or worry? If so, please describe.

- Do you easily get angry, or are you sensitive to the anger of others? If so, please describe.

- Do you frequently feel jealous, and if so, in what situations?

- Please describe any hobbies or passions that you have, and what you most enjoy about them.

- Do you prefer to have company around, or do you prefer or need to be alone? Please explain.

- What do you do for work, and how do you feel about your job (includes being a mom/homemaker, volunteer, etc)?

- Are there any traumas or griefs that may have occurred in your life that still seem to affect you on a regular basis? (this could be daily, weekly, monthly, yearly on the anniversary, etc)

D) Timeline & Medical History: (please use the back of this sheet or a separate sheet of paper if needed)

1) *Please list anything <u>important</u> from your personal medical history, including major diseases, accidents, injuries, illness patterns, surgeries, menstrual patterns or irregularities, pregnancies or abortions, medications or vaccines that potentially impacted your long-term mental, emotional or physical health. As best you can, please include approximate dates for these events, & place them in approximate order from most recent backwards to childhood.*

2) *Please list your family history (especially parents, grandparents & siblings) of diseases & illness (cancer, heart disease, diabetes, allergies, mental illness, alcoholism, etc), along with age & cause of death for those who are deceased.*

3) *If this intake is for a child, please list anything major that occurred during the pregnancy or delivery, including any medications or vaccinations the mother or baby received. Please also include a detailed vaccination history for the child, including names of vaccines and dates they were given.*

Is there anything else you feel it is important to know that could help us to better understand you or your complaints?

Please mail or email this completed form along with your signed consent form to the address below <u>at least one week prior to your appointment</u>:

Email Address:

druma@bioenergymedicalcenter.com