



Homeopathic Intake Form

Homeopathic consultation is facilitated when there is a complete picture of the individual's mental, emotional and physical states of health. This includes symptoms that affect both physical sensations (**what it feels like**), and function (**how it impacts you**) and what **ameliorates or aggravates** each symptom. *All information is kept confidential.*

Name _____ Age _____ Date: _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

E-mail _____

Occupation _____

Are you familiar with or have you ever had Homeopathic treatment?

If yes, what remedies have you taken and what remedies have helped?

In your opinion, what are your most important health concerns? List as many as you can in order of importance:

1) _____ 2) _____

3) _____ 4) _____

Have you had an experience (trauma, illness, vaccine, hospitalization) that did or still affects you deeply? Explain.

The general state of my health has been: Excellent ___ Good ___ Fair ___ Poor ___

Susan L. Guran, Integrative Homeopathy, Middlebury, Vermont

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Do you use any of the following?

Yes	Amount	Yes	Amount
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Laxatives
<input type="checkbox"/>	Other Drugs	<input type="checkbox"/>	Cortisone
<input type="checkbox"/>	Electric Blanket	<input type="checkbox"/>	Hormones
<input type="checkbox"/>	Herbs/Teas	<input type="checkbox"/>	Vitamins
<input type="checkbox"/>	Coffee	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	Cigarettes	<input type="checkbox"/>	Tranquilizers
<input type="checkbox"/>	Rec Drugs	<input type="checkbox"/>	Other therapies

Are you allergic to any drugs? (ex: penicillin)

Are you allergic to any foods or other substances?

What happens when you have an “allergy attack” or “sensitivity reaction”?

Has any **blood relative** had any of the following?

Yes	No	D.K. (<i>Don't Know</i>)	Yes	No	D.K.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Allergies			Gout
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Anemia			Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arthritis			Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Asthma			High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Bleeding			Seizure/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Cancer			Sickle Cell Anemia

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Yes	No	D.K. (<i>Don't Know</i>)		Yes	No	D.K.	
___	___	___	Diabetes	___	___	___	Stroke
___	___	___	Depression	___	___	___	Thyroid Trouble
___	___	___	Eczema	___	___	___	Tuberculosis
___	___	___	Glaucoma	___	___	___	Venereal Disease

If you have experienced any symptoms in the following body systems, either NOW or in the PAST, please provide a brief description.

Skin, Hair, Nails

Examples: rough, dry, scaly, bumpy, itchy, rashes, warts, moles, cysts, light or dark patches, increased hair growth, pimples, color changes in nails, hives, loss of hair, ridges, pits or spots on nails, infections, fungal symptoms . . .

Blood, Lymph, Immune

Examples: swollen or painful lymph nodes, wounds that heal slowly, difficulty stopping bleeding, swollen glands, easy bruising . . .

Endocrine

Examples: excessive hair growth, cold hands or feet, unexplained thirst, weakness, increased hunger, cold intolerance, heat intolerance, chronic fatigue, profuse sweating . . .

Head

Examples: dizziness, double vision, severe headaches, fainting spells, seizures/tics/spasms, injuries . . .

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Eyes

Examples: infections, near/far sighted, strabismus, blurred vision, floaters, sensitivity to light, injuries . . .

Ears

Examples: discharge, infections, pain, injuries, impaired hearing, tinnitus

Nose

Examples: nose bleeds, injury, sinus problems, loss of smell, obstruction or difficulty breathing through nose . . .

Mouth

Examples: sore mouth or tongue, bad breath, infections, gum disease, loss of teeth, speech difficulties . . .

Throat

Examples: persistent hoarseness, pain, difficulty swallowing, infections, loss of voice, swelling . .

Neck

Examples: stiffness, swelling, injuries . . .

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Respiratory

Examples: unexplained fever, night sweats, chest pain, shortness of breath, wheezing, daily cough, infections, difficulty breathing, difficulty breathing at night (wakes you up) . . .

Cardiovascular

Examples: chest pain when walking, varicose veins, ankle-swelling, hypertension (HBP), shortness of breath, leg pain (walking), palpitations (fluttering, pressure, skipping, rapid beat) . .

Digestive System

Examples: vomiting, nausea, blood in stools, hemorrhoids, heartburn, indigestion, difficulty swallowing, anal itching, excessive belching, stomach pain, distress from fats or greasy foods, yellow stool, clay-colored stool, black stool, stools containing undigested food, straining at stool, bad breath, bad taste in mouth, body odor (including feet), indigestion after meals (fullness, bloating, sourness, etc.), heavy or full feeling after eating, excessive lower bowel gas, stomach pain 5 or 6 hours after eating, history of constipation or diarrhea, nervousness, shaky feelings, symptoms that are-relieved by eating, strong craving for sweets or alcohol, waking up at night feeling hungry, loss of appetite, sudden weight loss, sudden weight gain, infection, injury, sleepy during the day, . . .

What foods, condiments, or other substances (i.e. chocolate, ice-cream, mustard, sour, spicy, etc.) do you **crave**?

Are you repelled by, or do you **dislike** any foods?

Are there any foods that do not agree with you? Please describe how this manifests for you.

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Are you thirsty? ____ For hot drinks _____ For cold drinks _____

Do you prefer ice in your drinks? ____ Do you like to chew ice? ____

Urogenital System

Examples: frequent urination, painful urination, night urination, trouble starting urine, trouble holding, frequent urging with scant urination . . .

Male Problems

Examples: prostate problems, discharge, difficulty achieving or maintaining an erection, painful erection, difficulty with ejaculation, lumps, swelling or pain in testicles, infection, infertility, injury . . .

Female Problems

Examples: discharges, difficulty feeling aroused, sex is painful, pelvic pain, menstrual flow is excessive/absent, bleeding or spotting between periods, pain before or during/after periods, infection, infertility, lumps in breast(s), premenstrual symptoms such as cramping, water retention, breast tenderness, headaches, depression, irritability . . .

Spine and Extremities

Examples: joint pain, swelling, stiffness, tingling, numbness, muscle cramps, backaches, burning soles of feet, injuries, arthritis . . .

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Nervous System

Examples: loss of balance, paralysis, lack of strength (seizures, stiffness), convulsions, numbness, tremor (shaking, involuntary movements, tics, spasms) . . .

General

Are you a warm or chilly person?

Are you sensitive to changes in weather? _____

sun _____ drafts _____ wind _____ noise _____ ordered environment _____

Do you remember your dreams?

Are there specific dreams or recurring themes to your dreams? If so, please describe.

Mental/Emotional

Examples: restlessness, anxiety, worry, nervousness, memory trouble, trouble concentrating, depression, crying spells, trouble sleeping, frequent nightmares, easily angered, feelings of worthlessness, mood swings, suicidal thoughts, fearfulness, loss of someone dear through death or separation, always putting others' interests before yours, hearing voices, think others want to hurt you, don't know how to relieve stress, great emphasis on order in your surroundings, generally late for appointments, tendency to leave things undone until the last minute, peculiar sensations

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What do you seek to understand?

(examples: machines, animals, plants, rocks/minerals, people, the workings of the universe, love, your community, your family, yourself, the earth . . .)

What do you seek to be?

(examples: respected, honored, protected, beautiful, athletic, indulged, strong, effective, perfect, nice, comfortable, adventurous, safe, trusted, clean, organized . . .)

What do you seek to feel?

(examples: peace, joy, comfort, love, inspiration, clarity, strength, passion, desire, relief . . .)

What do you fear?

(examples: poverty, embarrassment, speaking in a group, taking tests, bugs, heights, darkness, crowds, being alone, elevators, flying, etc.)

Do you experience mood swings?

What types of books or movies do you most enjoy?

Homeopathy is considered to be an alternative/preventative system of health care and is not intended to be a substitute for allopathic or traditional medicine. The therapy and information offered should not be construed by you, the client, to be a medical diagnosis of any disease or injury. You should consult with your physician for any serious medical condition.

While Susan Guran has received a formal education and clinical training in the science and art of Homeopathy, she is neither a medical doctor nor a licensed physician.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT:

Signature: _____ Date: _____

If patient is under 18 years, parental signature is required.