



Alternative Health & Chiropractic Wellness

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HOMEOPATHIC HEALTH FORM



Your consultation will be more complete when there is an accurate picture of your mental, emotional, biochemical and physical state of health. Your answers to this detailed questionnaire are important. If you need more space to answer any questions, there is additional space at the end of this form.

Name		Age	Birth Date	Sex	Date
Address		City		State	Zip
Telephone (Home)	Telephone (Work)	E-Mail			
Employer		Occupation			
Address		City		State	Zip
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____		Do you have any children? <input type="checkbox"/> No <input type="checkbox"/> Yes How Many? _____			
How did you hear about us?		Are you familiar with Homeopathy?			
Have you been treated homeopathically, and if so, by whom?					
Name: _____ Reason: _____ Result: _____					
Rated your overall level of health: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Other: _____					
List your most important health care problems/concerns in order of importance:					
1.		4.			
2.		5.			
3.		6.			
Onset of chief complaint, causation and other events occurring around the time the complaint began:					
What experiences in your life have affected you deeply from which you have never fully recovered?					
Childhood illnesses (Mark and date if possible):					
Disease	When	Disease	When		
<input type="checkbox"/> Rubella		<input type="checkbox"/> Mumps			
<input type="checkbox"/> Measles		<input type="checkbox"/> Chicken Pox			
<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Asthma			
<input type="checkbox"/> Scarlet Fever		<input type="checkbox"/> Polio			
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Other:			
Immunizations: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> HIB <input type="checkbox"/> Polio <input type="checkbox"/> Flu <input type="checkbox"/> Small Pox <input type="checkbox"/> TB <input type="checkbox"/> Pneumovac					
Adverse Reactions to/or chronic illnesses following immunizations:					

HEALTH FORM

Mark the following chronic illnesses or medical conditions you have had: C=Currently. P= Past. No mark = Never

	Allergies		Colitis/Irritable Bowel		Cavities
	Anemia		Diarrhea		Major Trauma
	Arthritis/Rheumatism		Epilepsy		Glaucoma
	Gout		Depression		Acne
	Hepatitis		Diabetes		Hemorrhoids
	Alcohol/Drug Abuse		Liver Disease		Syphilis/Gonorrhea
	Anorexia/Bulimia		Obesity		Swelling (Edema)
	Asthma		Hypertension		Pancreatitis
	Bleeding/Easy Bruising		Kidney Disease		Headaches/Migraines
	Repeated Strep Throat		Lung Disease		ARC/AIDS
	Tumors/Cancer		Eczema		Heartburn
	Seizures/Convulsions		Thyroid Disease		Herpes
	Crohn's Disease		Constipation		Stomach Ulcers
	Mononucleosis		Pneumonia		Psoriasis
	Chronic Infections		Psychosis/Mental Disorders		Raynaud's Disease
	Strokes		Chronic Sinusitis		Chronic Fatigue
	Meniere's Disease		PMS		Fibroids
	Congestive Heart Failure		Smoker		Parkinson's Disease
	Agarophobia/Anxiety Attacks		Bronchitis		Fibromyalgia

Hospitalizations:

Illness/Surgery	Date	Where

Mark any of the following foods, drugs, or medications that you routinely use:

	Coffee/Tea		Birth Control Pills		Cigarettes/Tobacco
	Alcohol/Drugs		Aspirin		Laxatives
	Sedatives		Vitamins		Thyroid Hormones Replacement
	Hormone Replacement		Herbal Products		Chinese Herbs
	Electric Blankets		Diet Pills		Dietary Supplements
	Wintergreen or Mints		Menthol or Camphor		Eucalyptus/Essential Oils

Do you have a strong desire/aversion for particular foods now or in the past?

Are there any foods that make you feel bad or aggravate your symptoms?

List all prescription medications you are currently taking:

List all allergies/sensitivities to medications or environmental substances:

HEALTH FORM

Mark the following chronic illnesses or medical conditions you have had: C=Currently. P= Past. No mark = Never

<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Seizure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sexual Diseases
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Genetic Diseases	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Mental Disorders

Do you have now or have you had the following symptoms? (Use scale from 0 to 5: 0=never, 1=mild, 5=severe)

Mental Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Cry easily (for no obvious cause)			Tend to theorize
		Cry when thanked			Pessimistic
		Cry from anxiety			Tend to worry about everything
		Cry from self-pity			Anxious in company
		Moved to tears from music			Anxious when anything is expected of you
		Relieved by crying			Anxious with a hurried feeling
		Cry premenstrually			Anxious and cautious
		Like sympathy			Anxious and indecisive
		Dislike sympathy			Yielding/passive
		Sympathetic			Lack confidence
		Lack sympathy			Fearful of others opinion
		Tend to sigh frequently			Avoid undertaking new things for fear of failure
		Tend to brood or sulk			Timid about public speaking (but capable)
		Irritable (at the least thing)			Apprehensive (e.g., before a performance)
		Irritable premenstrually			Inhibited
		Easily angered			Impressionable
		Dictatorial (especially at home)			Think rapidly
		Angry when contradicted			Think slowly
		Prone to contradict			Talkative and frequently change subjects
		Impulsive			Tend to procrastination
		Changeable and inconsistent			Restless while at work
		Jealous			Anxious on waking in the morning
		Suspicious			Anxious about own health
		Critical			Suppress grief following bereavement
		Fastidious			Affectionate
		Concerned with precision/accuracy			Feel better mentally after vigorous exercise
		Conscientious about trivial matters			Dislike for being touched
		Vain			Clairvoyant
		Egotistical			Low sex drive (female)
		Ambitious			Low sex drive (male)

Fears (0, 1 to 5)

Now	Past		Now	Past	
		Heights			Being late
		Enclosed spaces			Being hurt emotionally
		Crowds/public places			Being poisoned (by bad food or pollution)
		Mice			Illness
		Snakes			Insanity
		Water			Cancer
		Thunderstorms			Death
		Sharp Pointed objects (needles)			For the health of your family
		Ghosts			Failure in business
		Darkness			Poverty
		Burglars			Loss of Self-control
		Being alone			Physical/mental exertion (due to lack of stamina)

Food Preferences (0, 1 to 5)

Now	Past		Now	Past	
		Like warm foods and drinks			Pastries disagree
		Dislike warm foods			Like salty foods
		Like raw foods			Dislike salty foods
		Lose appetite during menstruation			Like oysters
		Mixture of foods disagree			Dislike fish
		Eat to bursting point			Shellfish disagree
		Fruit disagrees			Like lemons
		Dislike fruit			Like pickles
		Like eggs (especially soft-boiled eggs)			Dislike tomatoes
		Dislike eggs			Like spicy foods
		Beans/peas disagree			Garlic disagrees
		Like starchy foods			Onions disagree
		Like bread and butter			Like milk
		Like rich, fatty foods			Milk disagrees
		Rich, fatty foods cause digestive upset			Reluctant to take breast milk as infant
		Like ice cream			Hot drinks disagree
		Like peanut butter			Iced drinks disagree
		Like cheese			Like carbonated drinks
		Like olive oil			Like alcohol
		Dislike pork			Beer disagrees
		Like sweet foods			Little thirst
		Dislike sweet foods			Like coffee
		Like sweet foods, but they disagree			Dislike coffee
		Like sweet foods, but not upset by them			Coffee disagrees

General Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Warm and made worse by heat			Eyes are sensitive to sunlight
		Ailments are worse in stuffy rooms			Sensitivity to the slightest noise
		Feet are hot in bed (stick them out from under sheets)			Suffer a headache or feel faint on missing a meal
		Chilly but made worse by heat			Feel better when fasting
		Chilly and better with heat			Feel better after a short nap
		Feet are sweaty and smelly			Ailments are relieved by onset of a menstruation
		Ailments are worse after sweating			Ailments seem worse between 4-8 A.M./P.M.
		Head is sweaty in bed			Ailments seem worse between 4-6 A.M./P.M.
		Ailments are worse from prolonged standing			Ailments seem worse between 1-2 A.M.
		Ailments are worse in cold, wet weather			Ailments seem worse between 2-5 A.M.
		Ailments are worse in cold, dry weather			Ailments are worse in the Spring
		Ailments are worse in windy weather			Ailments are worse around full moon
		Feel better from sea air			Ailments are worse in the morning and evening
		Feel worse from sea air			Ailments are worse from sunset to sunrise
		Love to watch thunderstorms			Avoid lying on left side of the body in bed
		Suffer a headache before thunder storm			Avoid lying on right side of the body in bed
		Sensitive to smells			Prone to left-sided complaints
		Sensitive to the smell of tobacco			Prone to right-sided complaints

General Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Warm-blooded Person			Cold-blooded Person
		Thirsty			Thirstless
		Worse in the Wind			Worse in Humidity
		Sensitive to Noise			Worse in Heat
		Worse from Changes in Weather			Periodic Symptoms
		Fatigue/Fatigues Easily			Environmental Allergies
		Night Sweats			Chronic Infections

Endocrine or Hormone Related Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Internal Heat			Internal Chilliness
		Weight Loss			Weight Gain
		Increased Hair Growth			Swelling in Extremities
		Cold Hands and Feet			Increased / Excessive Thirst
		Night-time Urination			Weakness
		Prefer Hot Weather			Prefer Cold Weather
		Decreased Appetite			Increased Appetite
		Fatigue			Depression

Skin Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Rough Skin, Dry Skin (Circle)			Skin Infections
		Itchy Skin			Hives or Urticaria
		Rashes			Nail Changes
		Moles, Warts, Cysts (Circle)			Hair Loss
		Pimples/Acne			Boils
		Herpes			Discoloration

Ear Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Discharge from Ears			Chronic Ear Infections
		Pain in the Ears			Hearing Loss
		Ringing in the Ears			Itching in the Ears

Head Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Dizziness			Fainting Spells
		Seizures/Epilepsy			Head Injuries
		Headaches			Migraines
		Hair loss			Heaviness
		Aversion to Light/Sun			Discharges
		Have to Wear Sunglasses			Infections/Styes
		Eye Pain			Itchy Eyes

Nose Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Nose Bleeds			Sinus Infections
		Loss of Smell			Breathing Problems
		Discharge/Runny			Frequent Colds
		Allergies			Obstructions
		Sneezing			Post-Nasal Drip

Mouth/Teeth Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Gum/Teeth Infections			Canker Sores / Aphthae
		Fever Blisters / Cold Sores			Cracked Lips
		Bad Breaths			Increased Salivation
		Loss of Teeth			Many Cavities
		Dry Mouth			Tonsillitis

Neck/Throat Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Persistent Hoarseness			Throat Pain
		Difficulty Swallowing			Chronic Infection
		Loss of Voice			Swelling
		Stiffness			Injuries
		Lump in Throat			Swollen Glands

Cardiovascular Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Ankle/Leg Swelling			High Blood Pressure
		Heart Palpitations			Leg Pains
		Chest Pain at Rest			Clotting Problems
		Phlebitis			Anemia

Respiratory Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Wheezing			Persistent Cough
		Difficulty Breathing			Shortness of Breath
		Have to Sit Up in Bed at Night			Chronic Sputum Expectoration
		Bloody Sputum			Asthma

Digestive Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Heartburn			Bloating
		Gas			Belching
		Diarrhea			Constipation
		Rectal Itching			Hemorrhoids
		Pain			Indigestion After Meals
		Diarrhea & Constipation			Nervous Stomach
		Stomach Ulcers			Hiatal Hernia
		Yellow or Clay Colored Stools			Straining at Stools
		Blood in Stools			Mucous in Stool
		Anorexia/Bulimia			Nervous Stomach

Urogenital System (0, 1 to 5)

Now	Past		Now	Past	
		Frequent Urination			Painful Urination
		Difficulty Holding Urine			Difficulty Urinating
		Involuntary Urination			Blood in Urine
		Prostate Problems			Discharge/Infections
		Painful Erections			Difficulty with Erections
		Infertility			Swelling in Testicles

Musculoskeletal Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Muscle Pain			Joint Pain
		Bone Pain			Numbness/Tingling
		Traumatic Injuries			Weakness

Nervous System Symptoms (0, 1 to 5)

Now	Past		Now	Past	
		Paralysis			Convulsions
		Tremor or Shaking			Memory Loss
		Numbness/Tingling			Twitching
		Insomnia			Anxiety Attacks
		Strokes			Fainting/Light-headed

Female (0, 1 to 5)

Now	Past		Now	Past	
		Vaginal Discharge			Painful Intercourse
		Few or No Orgasms			Cervical Problems
		Infertility			Vaginal Itching
		Positive PAP Smear			Irregular Periods
		PMS			Miscarriages
		Painful Menstruation (Cramps)			Bleeding Between Menses
		Excessive Menstrual Flow			
Onset of Menstruation:		Length of Periods:		Miscarriages:	
Abortions:		Number of Pregnancies:		Number of Births:	
Complications During Pregnancy:					
Did you breast feed your children?			How Long?		

Please use the space below for any further information you wish to provide:

Please don't write in this section. This space is reserved for doctor comments.