Homeopathy and Advanced Biofeedback

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● Working with you to wellness……
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Last Name_____ Middle_____First_____Date_____
Address_____City_____State_____
Zip_____ Phone (Home)_____(Cell)_____Sex_____
Date of Birth_____Age_____Occupation_____
Duration of Occupation_____ Referred by_____E-mail_____
Place of birth_____

●PERSONAL HISTORY

Current Health Concerns – Please include when each symptom first began, how long the symptoms last and the pattern of recurrence. Explain each symptom/condition as thoroughly as possible.

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•Symptoms **Began/Length/Recurrence**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Symptoms/Conditions – Please include when they began and ended.

●Previous Symptoms **Began/Ended**

_____
_____
_____
_____

●Surgeries **Date**

_____
_____
_____
_____

Any other complaints, symptoms or conditions:

_____
_____
_____

What is your blood type? A____ B____ AB____ O____ Don't know_____

•FAMILY HISTORY

Father's Ailments:

_____
_____ _____
_____

Mother's Ailments:

_____
_____

Paternal Grandmother's Ailments:_____
Paternal Grandfather's Ailments:_____
Maternal Grandmother's Ailments:_____
Maternal Grandfather's Ailments:_____
Childrens Ailments:_____
Did your mother have difficulties when pregnant with you?_____with the delivery?_____
Did your mother have any difficulties before your birth? (miscarriages, still births, etc)
_____

GENERAL QUESTIONS

Were you breast fed or bottle fed?_____ Were you shy as a child?_____
What fears did you have as a child? Dark room_____ Heights_____ Animals_____ Strangers_____
Do you still have any of those fears? _____Which ones?_____
Do you dislike being in a crowd of people?_____ Are you afraid of small spaces_____
Do heights make you dizzy?_____ Are you afraid of heights?_____ Do you ever want to jump while standing on a high place?_____ Are you afraid of animals or insects?_____
As a child were you closer to your mother or father_____Explain_____
_____
Are you married?_____ At what age were you married?_____ How many marriages_____
Do you have children?_____ How many?_____ At what ages did you have children?_____

Please answer Yes or No to the following. Do you frequently have?
Allergies____ ___Sinus problems_____ Joint or Muscle aches_____ Skin Problems_____
Colds_____ Fevers_____ Constipation _____ Diarrhea _____Dizzy spells_____ Earaches_____
Edema_____ Ringing in the ears_____ Chills_____ Eye problems_____ Sore throats_____
Headaches_____

•Do you have a pace maker? yes_____ no____

Have you ever had epilepsy or a history of seizures? yes_____ no____ past____ present_____

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PERSONAL QUESTIONS

If everything were healthy for you to eat, what would you most like to eat?
_____
_____

Do you crave (1) or dislike (0) any of the following foods: (Crave means you have to have it.)
Sweets (___) chocolate (___) ice cream (___) milk (___) potatoes (___) meat fat (___) mustard (___) fish (___) meats (___) Spicy food (___) horseradish (___) butter (___) salt (___) oranges (___) ice (___) fruit juice (___) soda (___) coffee (___) lemons (___) tea (___) water (___) oysters (___) fruit (___) eggs (___) sour pickles (___)
Do you keep your home neat and tidy?_____ Does disorganization bother you?_____
Can you throw your clothes on the chair before going to bed?_____
Are you bothered by scary movies or unpleasant news on T.V._____
Are you unusually sensitive?_____ To what? Noise_____
Smells_____Other_____
Do you prefer the companionship of animals more than being with people? _____
Do you prefer to keep your feelings to yourself and not express them?_____
Do you remember injustices a long time?_____ Do you keep your thoughts to yourself?_____
Do you experience angry outbursts?_____ After you have lost control do you feel relieved?_____
Sorry?_____ Guilty?_____ Upset?_____ Depressed?_____ Still angry?_____ Angry at yourself?_____
Does consolation from another person make you uncomfortable?_____ Better?_____
Irritated?_____
Do you like making decisions?_____ Do you have difficulty making decisions?_____
Describe dreams you had as a child?_____
_____
Describe dreams you have had recently?
_____
•_____
Have you ever had thoughts of suicide?_____ When?_____ What happened?_____
_____
Do you smoke? Cigarettes_____ Other_____Present_____ Past_____How many years?_____Recreational drugs?_____How long?_____

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•PHYSICAL TRAITS

Do you usually feel warm or cool?_____ Do you feel better in warm or cool weather?_____
What time do you feel best, have the most energy and think clearest?_____
What is your worst time of day, when you are tired or irritable?_____
Do you feel better doing things?_____ or sitting still?_____ Do you do things quickly?_____
Do you exercise?_____ What do you do for exercise?_____
Do you feel better if you exercise? _____

Are your symptoms worse/better before a rainstorm approaches?_____
Is your mouth often dry?_____ Are you thirsty during the day?_____ During the night?_____
Do you like your drinks cold?_____ ice cold?_____ hot?_____ room temperature_____
Do you have difficulty swallowing?_____ liquids?_____ solids?_____ when?_____
Do you drink liquids slowly?_____ in gulps?_____ rapidly?_____ in small sips? _____
Are you frequently constipated?_____ Does your constipation make you uncomfortable_____
Do you often have diarrhea?_____ When?_____ Do you have "loose" bowels when nervous?_____
Do you become gassy or have abdominal distention_____ How long after eating?_____
Can you be relieved by burping?_____ by passing gas?_____ Is the gas foul smelling?_____
How often do you get up to urinate at night?_____ Do you void a large amount?_____
Are you bothered by clothes touching or pressing against your abdomen?_____ neck?_____
Do you have difficulty falling asleep?_____ Returning to sleep?_____
Do you get hot /warm at night?_____ Cold?_____ Do you like a warm room?_____ Cool?_____
Do you sleep with your feet out from under the covers?_____ Are your arms on top of the covers?_____
Do you sweat during the night?_____What part of your body sweats at night?_____
Do you feel worse during the evening hours?_____ At night?_____
When you wake up in the morning, how do you feel?_____
Are your feet sore when you get up in the morning?_____ Do you feel worse in the morning?_____
Have you had frequent infections of the throat, glands, or ears?_____
Have you had any type of itchy rash of the skin in the past?_____ When?_____ What?_____
Have you had a blow to the head or concussion?_____ When?_____
Do you enjoy _____ dislike _____ or are you indifferent_____ to your sex life?

•<u>WOMEN'S SECTION</u>

At what age did your period begin?_____ Was it regular?_____ Is it now?_____
Have you ever had any major problems with your periods?_____ When_____ What was the problem?
_____
How long is your period?_____ Is there clotting?_____ What color is the blood?_____
Are you better before your period _____ During your period _____ After your period?_____ Any menstrual cramping or pain?_____
How many pregnancies have you had?_____ abortions?_____ miscarriages?_____
When you were pregnant did you develop brown spots on your face?_____ Other troubles?_____
What type of birth control, if any, are you currently using?_____ How long?_____
Have you ever been on birth control pills?_____ For how long?_____ Problems?_____
Any pain with intercourse?_____ Vaginal dryness?_____ Chronic yeast infections?_____
Breast pain?_____ Fibrous breasts?_____ Menopausal symptoms? (Please list)_____

_____

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•MEN'S SECTION

Have you had any problems with your prostrate?_____
Describe_____
_____
Do you have any blood in your urine?_____ When did this begin?_____
Do you have any problems with impotence?_____ When does this occur?_____
_____
•How long?_____

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•SPIRITUAL BELIEF

Do you have a spiritual belief? Yes_____ No_____

CONFIRMATION

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I WANT THE MOST RELIEF FROM:

_____
_____
_____
_____
_____

•END

Any other comments that were not covered in the questionnaire? (Use the space below)

Supplements Taking Currently

Prescription Medications Taking Currently and Last 2 years

Nutritional Assessment

Fat digestion

1. Do you frequently have knots in your shoulders or upper back area?

Yes___ No___

Protein digestion

1. When you plug your ears and chew, do you hear a cracking noise?

Yes___No___

B vitamin deficiency

1.When you put the backs of your hands together, do you feel pain?

Yes___No___

Thyroid

1. Do you have lines on the bottom of your neck and the top above your thyroid?

Yes___No___

1.Are you frequently tired in the afternoon?

Yes___No___

1. Are you frequently cold?

Yes___No___

1.If you have fat around your stomach area, is the fat more jelly like?

Yes___No___

1. Are you frequently constipated?

Yes___No___

Adrenals

1. Are you frequently hot?

Yes___No___

1. Do you wake at night wide awake?

2.Yes___No___

3.Is the fat around your stomach area hard?

Yes___No___

Amylase production

1.Is your mouth dry when you eat carbohydrates like breads, crackers, etc.

Yes___No___

Three Day Food Journal

Name_____

Dates_____

Breakfast

Lunch

Dinner