Solutions Health and Wellness Center

NOLA DANIEL, CNC, DIHom
8470 Hwy 74, Fairburn, GA 30213
Phone: (770) 306-2520 Fax: (770) 306-2201
nola@SolutionsHealthandWellness.com
www.SolutionsHealthandWellness.com

Homeopathic Intake Form

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Birth Date: _____ Age: _____ Birth Time: _____

Day of the week you were born: _____ Birthplace: _____

Children/Names/Ages: _____

Specific philosophy or religion practiced now? _____ As a child? _____

Sex: M/F Marital Status: Single / Married / Living with partner / Separated / Divorced / Widowed

Live alone / Live with: _____

Emergency Contact / Relationship: _____

Phone: _____

Referred by: _____

Have you had or are you familiar with homeopathic treatment? Y / N If yes, when and what? _____

_____

List ALL medications, vitamins, or herbs you are currently taking, how long you've taken each substance and why: _____

_____

_____

_____

_____

_____

Please list your mental, emotional and/or physical health problems, from the most to the least significant:

Condition:

When did it begin?

Anything that makes it better or worse?

Condition:

When did it begin?

Anything that makes it better or worse?

Condition:

When did it begin?

Anything that makes it better or worse?

Is there any other information about your health that you would like to add?

What do you think is at the heart of your problems?

Current goals or dreams?

Any particular fears – now or as a child?

What time of day do you experience the lowest energy and vitality?

Are most of your symptoms on the right or left side of your body?

Any particular stresses, such as relationships, job, school, finances, children, etc.

Please list in chronological order any major illnesses, accidents, grief, and emotional or physical traumas you have experienced. Give your approximate age at the time of the event. Please use the back of this page if necessary.

Age: Event:

Please state the health of your mother during her pregnancy with you?

Was your birth normal?

Were you breastfed? How long?

Give any information you have about your health during your infancy:

How has your general state of health been? Excellent / Good / Fair / Poor

Do you wake up refreshed in the morning?

What is your energy level on a scale of 1 to 10? (Increasing scale)
Mark the childhood illnesses you have had and give your approximate age at the time:

Childhood Illness:	Age:
Polio	
Asthma	
Chicken Pox	
Rubella	
Measles	
Whooping Cough	
Scarlet Fever	
Mumps	
Other:	

Mark any immunizations you have received and give your approximate age at the time:

Immunization	Age
Smallpox	
DPT	
Typhoid	
Flu	
MMR	
Polio	
TB	
Hepatitis B	
Other:	

Did you experience any reaction to any immunization? Y / N If yes, explain:

Mark any tests that you have had. Indicate your age at the time:

Test	Age
Chest X-ray	
Kidney X-ray	
G.I. series	
Colon X-ray	
Gallbladder	
X-ray	
EKG	
TB test	
Other:	

Underline the following conditions that apply to your now and put a ✓ beside the ones that have applied to you in the past.

Allergies
Diabetes
Excessive Drinking
Drug Usage
Eczema
Liver Disease
Jaundice
Tuberculosis
Kidney Disease
Dehydration
Gonorrhea
Syphilis
Migraines
Chlamydia
Anemia
Gout
Mental Problems
Head Injury
Hyperthyroidism
Cancer
Tumors
Pneumonia
Rheumatism
Warts
Herpes
AIDS
Hypothyroidism
Emphysema
Frequent colds
Bronchitis
Heart condition
Sinusitis
Hepatitis
Obesity
Asthma
Easy Bleeding
Easy Bruising

HOSPITALIZATIONS

Reason for Hospitalizations: Date

Mark any of the following that you use and indicate the amount or frequency of usage.

Substance / Item	Amount / Frequency
Coffee	
Cigarettes	
Alcohol	
Laxatives	
Cortisone medication	
Aspirin	
Hormone treatment	
Vitamins	
Medicinal herbs or teas	
Recreational drugs	
Birth control pills	
Sedatives or tranquilizers	
Other drugs	
Diet pills	
Diet drinks	

Are you allergic to any drugs? Y / N If yes, which ones? What happens?

Are you allergic to any foods or other substances? Y / N If yes, which ones? What happens?

FAMILY HISTORY

For the following family members, please put a ✓ beside the ones who are deceased. Indicate current age or age deceased, and list their ailments.

Family Member	Deceased?	Current Age/Age Deceased	Ailments
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please mark any condition(s) that any of your blood relatives have had.

Allergies	Eczema	Heart Attack
Anemia	Skin Disorder	High blood pressure
Arthritis	Glaucoma	Seizure
Asthma	Gout	Sickle Cell Anemia
AIDS	Hay fever	Stroke
Easy bleeding	Gonorrhea	Thyroid disorder
Easy bruising	Syphilis	Tuberculosis
Cancer	Venereal Disease	Learning Disabilities
Diabetes	Alcoholism	Suicide attempts
Depression	Abuse	Addictions

MILITARY SERVICE

Did you serve in the Military? Y / N If yes, where?_____When? _____

How long did you serve? _____

Did you contract any illnesses while serving? Y / N If yes, what?

Did you have any vaccinations during your time in the military? Y /N If yes, which?

DIETARY AND DIGESTIVE INFORMATION

What is a typical day's diet?

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

How often do you eat?

Any particular food cravings or aversions?

Do any foods aggravate you? Y /N

If yes, in what way?

How much water do you drink?

Has your appetite changed? Y / N If yes, has it increased or decreased?

SYMPTOMS

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

SKIN

- ❒ Rough / Dry / Scaly / Bumpy / Itchy / Rashes / Warts / Moles / Cysts
- ❒ Light / Dark patches of skin
- ❒ Increased hair growth in unusual places
- ❒ Pimples: Y/N Where?
- ❒ Color changes in nails
- ❒ Hives
- ❒ Loss of hair: Y / N Where?
- ❒ Nails: Ridges / Pits / Spots
- ❒ Infections: Y / N How often?

BLOOD-LYMPH-IMMUNE SYSTEM

- ❒ Swollen or painful lymph nodes
- ❒ Bleeding from unusual places
- ❒ Wounds that heal slowly
- ❒ Swollen glands
- ❒ Difficulty stopping bleeding
- ❒ Easy bruising
- ❒ Anemia

ENDOCRINE

- ❒ Excessive hair growth: Where? _____
- ❒ Unexplained weight loss or gain? Which? _____
- ❒ Can't stand the heat
- ❒ Can't stand the cold
- ❒ Prefer hot weather
- ❒ Prefer cold weather
- ❒ Cold hands / feet
- ❒ Weakness
- ❒ Increased / Decreased thirst
- ❒ Increased / Decreased hunger
- ❒ Excessive sweating: Where? _____
- ❒ Night sweats

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

HEAD

- ❒ Dizziness
- ❒ Double vison
- ❒ Severe headaches
- ❒ Migraines
- ❒ Seizures / Fits
- ❒ Fainting spells
- ❒ Injury / blow to the head

EYES

- ❒ Poor eyesight: Near / Farsighted
- ❒ Eyes sensitive to light
- ❒ Frequent infections
- ❒ Injury to eye

EARS

- ❒ Discharge from the ears
- ❒ Frequent infections
- ❒ Hearing trouble
- ❒ Injury to the ears
- ❒ Ringing or other sounds in the ears
- ❒ Pain in the ears

NOSE

- ❒ Nose bleeds
- ❒ Sinus problems
- ❒ Loss of smell
- ❒ Injury to the nose
- ❒ Difficulty breathing through the nose

MOUTH

- ❒ Sore mouth / tongue
- ❒ Cold sores
- ❒ Poor dentition
- ❒ Dental fillings? Y / N What kind? _____
- ❒ Crown
- ❒ Root canal
- ❒ Infections
- ❒ Loss of teeth
- ❒ Speech difficulty
- ❒ Bridges

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

THROAT

- ❒ Infections
- ❒ Persistent hoarseness
- ❒ Difficulty swallowing
- ❒ Loss of voice
- ❒ Swelling pain

NECK

- ❒ Stiffness: Improved by?
  Worsened by?
- ❒ Swelling: Improved by?
  Worsened by?
- ❒ Injury to the neck

RESPIRATORY SYSTEM

- ❒ Unexplained fever
- ❒ Chest pain with breathing
- ❒ Daily cough
- ❒ Difficulty breathing at night
- ❒ Night sweats
- ❒ Infections
- ❒ Shortness of breath

CARDIOVASCULAR

- ❒ Chest pain upon waking
- ❒ Ankle swelling
- ❒ Shortness of breath
- ❒ Heart palpitations
- ❒ Skipping heart beat
- ❒ Fluttering
- ❒ Leg vein trouble
- ❒ Leg pain when walking
- ❒ High blood pressure
- ❒ Difficulty climbing stairs
- ❒ Rheumatic fever: Y / N When?

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

GASTROINTESTINAL

- ❒ Color of stools: green / yellow / clay
- ❒ Stool has foul odor / shows undigested food
- ❒ Bad breath
- ❒ Bad taste in mouth / body odor (also feet)
- ❒ Flatulence
- ❒ Sleepy during the day
- ❒ Symptoms aggravated by worry and tension
- ❒ Loss of appetite
- ❒ Constipation / Diarrhea
- ❒ Feel better / worse in the afternoon
- ❒ Feel better / worse in the morning
- ❒ Belching / stomach cramps / colicky sensations
- ❒ Injury to the stomach
- ❒ Infection
- ❒ Weight gain / weight loss
- ❒ Overweight
- ❒ Nervous, shaky feeling, and/or headaches, relieved by eating sweets
- ❒ Irritable if late for a meal, miss a meal or before breakfast
- ❒ Sudden, strong craving for sweets or alcohol
- ❒ Wake up hungry during the night

SPINE AND EXTREMITIES

- ❒ Joint pain / swelling / stiffness / tingling / numbness
- ❒ Muscle cramps
- ❒ Backaches
- ❒ Unusual redness on palms of hands
- ❒ Burning of soles of feet
- ❒ Spinal pain? Y / N Where?

- ❒ Arthritis? Y / N Where?
- ❒ Injury? Y / N Where?

NERVOUS

- ❒ Loss of balance
- ❒ Paralysis
- ❒ Lack of strength
- ❒ Convulsions (seizure, stiffness)
- ❒ Involuntary movements
- ❒ Tremors (shaking, trembling)
- ❒ Numbness

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

MENTAL

- ❒ Nervousness
- ❒ Restlessness
- ❒ Excessive worry
- ❒ Memory problems
- ❒ Trouble concentrating
- ❒ Crying spells
- ❒ Mood swings
- ❒ Excessive stress in life
- ❒ Feelings of worthlessness
- ❒ Cannot remember dreams
- ❒ Trouble sleeping
- ❒ Frequent nightmares
- ❒ Depression
- ❒ Easily angered
- ❒ Fearful
- ❒ Hear voices
- ❒ See things others do not
- ❒ Suicidal
- ❒ Feel better as a result of exercise
- ❒ Trouble getting along with people
- ❒ Loss of someone dear through death or separation
- ❒ Always put others' interest before mine
- ❒ Think others want to hurt me
- ❒ Don't' know how to relieve stress
- ❒ Generally late for appointments
- ❒ Frequently procrastinates
- ❒ Peculiar sensations Y / N What?
- ❒ Obsessive habits or thoughts
- ❒ If you have recurring dreams, what are they about?

GENITO-URINARY SYSTEM

- ❒ Frequent urination
- ❒ Painful urination
- ❒ What color is your urine?
- ❒ Trouble starting urine
- ❒ Blood in urine
- ❒ Do you have night urination

MALE PROBLEMS

- ❒ Prostate problems
- ❒ Discharge from penis
- ❒ Difficulty achieving or maintaining an erection
- ❒ Painful erection
- ❒ Difficulty ejaculating
- ❒ Premature ejaculation
- ❒ Infection: Y / N Where?
- ❒ Infertility
- ❒ Injury: Y / N Where?
- ❒ Testicles: lumps / swelling / pain

Underline the symptoms that apply to you now and put a ✓ beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

FEMALE PROBLEMS

- ❒ Discharge from vagina
- ❒ Painful sex
- ❒ No lubrication when aroused
- ❒ Never or seldom have orgasms
- ❒ Lumps in breast
- ❒ Menstrual flow: excessive / absent
- ❒ Bleeding or spotting between periods
- ❒ Painful period: before / during /after
- ❒ Pelvic pain
- ❒ Infertility

Premenstrual symptoms: cramping / water retention / breast tenderness / headaches / depression / irritability / other?

Menopausal symptoms: Y / N If yes, since when? _____
What are your menopausal symptoms?

Infection: Where? When?

ADDITIONAL QUESTIONS FOR WOMEN

Number of births _____ Number of pregnancies _____

Number of abortions _____ Number of miscarriages _____

Nursed children? Y / N If yes, how long? _____

Did you have any complications with the pregnancies? _____

How old were you when you started menstruating? _____

How often do you have your period? _____

How long does your period usually last? _____

What is the number of tampons or pads used daily? _____

What is the date of your last period? _____

What type of contraception do you use? _____

Have you ever or do you now use any kind of hormone pill? _____

_____

FINAL REMARKS

Is there anything you would like to add?