



Client Health Questionnaire

Name: _____ **Date:** _____

List occupations that your parents, spouse, roommates, etc., may have held that might include some sort of chemical exposure, from childhood forward.

List any situations you (the client) may have had that included exposures to chemicals, especially petroleum, metals, pesticides, paints, etc. _____

Are you currently on any supplements, herbal, homeopathic, ayurvedic or other natural remedies at this time? Please list: _____

Have you ever been, or are you currently under the care of a mental health professional (Psychiatrist, psychologist, therapist, social worker, etc.) _____

Name & Phone Number: _____

Are you on, or have you been on any psychotropic drugs, such as antidepressants, anti-anxiety, sleep, stimulant, anti-seizure or other medications?

If yes, current medications: _____

Past medications, if known: _____

Do you have, or have you in the past had mercury-silver amalgam fillings in teeth? _____ root canals? _____ amalgam removal?

_____ If so, when? _____

Are you pregnant or nursing a child? _____

Include any of the following issues on the next page into the “Timeline” where appropriate. Be sure to elaborate on any item that requires more information on additional paper. Details are significant.

	AIDS/HIV		Hyperthyroidism
	Abnormal Pap Smear		Hypoglycemia (Low Blood Sugar)
	ADD (Attention Deficit Disorder)		Hypotension (Low Blood Pressure)
	ADHD (Attention Deficit Hyperactive Disorder)		Hypothyroidism
	Allergic Dermatitis		IBS (Inflammatory Bowel Disorder)
	Allergic Reaction to Medication		Impotence
	Allergic Rhinitis (Hay Fever)		Influenza
	ALS (Lou Gehrig's)		Irritability
	Anorexia/Bulimia		Liver Disorders
	ASD (Autism Spectrum Disorder)		Loss of Limb
	Asperger's Syndrome		Lupus
	Asthma		Malaria/Yellow Fever/Typhoid...
	Athlete's Foot		Measles
	Bipolar Disorder (Manic/Depressive)		Meningitis
	Bloating/Gas (Chronic)		Menses (Difficult/Heavy/Irregular)
	Bronchitis (Chronic)		Mononucleosis
	Cancer		Morgellon's Syndrome
	Chicken Pox		Multiple Sclerosis
	Chlamydia		Mumps
	Chronic Ear Infections		Muscular Dystrophy
	Chronic Fatigue Syndrome		Near Drowning
	Chronic Pain		Osteoarthritis
	Chronic Sinusitis		Parasites
	Constipation (Chronic)		Parkinson's Syndrome
	Crohn's Disease		PDD (Pervasive Developmental Disorder)
	Depression		PMS (Premenstrual Syndrome)
	Diabetes		Pneumonia
	Diabetes (Gestational)		Pregnancy Problems
	Diarrhea (Chronic)		Prostate Disease
	Dizziness/Syncope		Psoriasis
	Down Syndrome		Rheumatoid Arthritis
	Dry Eyes		Rubella
	Eczema		Scarlet Fever/Scarlatina/Fifth's Disease
	ED (Erectile Dysfunction)		Seizures
	Emphysema		Sensory Integration Disorders
	Epstein-Barre Virus		Sjogren's Disease
	Fainting/Blackout		Spinal or Disc Disorders
	Fever Blisters (Cold Sores)		Sprains/Strains
	Fibromyalgia		Staph Infection/MRSA
	Fractures		Strep Infection
	Fungal Disorders of the Skin		Surgeries
	GERD (Esophageal Reflux Disease)		Syphilis
	Glaucoma/Cataracts		Toxemia of Pregnancy
	Gonorrhea		Tuberculosis
	Growing Pains		Unconsciousness
	Head Trauma		UTI (Urinary Tract Infection/Disorder)
	Heat Stroke		Vaccine Reactions
	Hepatitis		Vaginal Discharge/Itching/Irritation
	Herpes/Shingles		Vision Disorders
	Hot Flashes (Menopausal)		Whooping Cough
	Hyperlipidemia (High Cholesterol)		Yeast Infections
	Hypertension (Gestational)		Other
	Hypertension (High Blood Pressure)		Other

Have you ever smoked? _____ Lived with a smoker? _____

Have you (the client) ever taken the following medications:

- | | |
|---|---|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Cortisone/steroids (oral, topical or injected) |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Decongestants |
| <input type="checkbox"/> Anti-fungal | <input type="checkbox"/> Inhalers/nebulizers for asthma |

Have you (the client) ever been treated by:

- Chiropractor Osteopath (D.O.) Nutritionist

Have you (the client) received vaccinations? _____ Please provide a vaccine record, if so.

Did you (the client) receive a Hepatitis B vaccination near birth? _____

Was your (the client's) delivery induced? _____ Anesthetized? _____

Have you (the client) ever been subjected to the following medical tests or procedures?

- X-rays (including dental)
- CT Scans
- Upper or lower Gastrointestinal Series with Barium swallow/enema
- MRI
- Injection of radioactive dyes
- Day surgery (please list) _____
- Surgery under general anesthesia (list) _____
- _____
- Surgery under local anesthetic, including dental (list) _____
- _____
- Implants of any sort, including dental (list) _____
- _____
- Reconstructive surgery (list) _____
- _____
- Biopsies
- Spinal tap
- Blood draws

Have you (the client) ever been treated for biofilm? _____

If so, when was the last treatment? _____

Have you (the client) suffered any recent illnesses?

What illness? _____ When? _____

Have you (the client) had any recent emotional traumas? Please describe when and what happened, briefly: _____

Have you (the client) ever had:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Back injury |
| <input type="checkbox"/> Joint injury | <input type="checkbox"/> "Growing pains" | <input type="checkbox"/> Loss of limb |
| <input type="checkbox"/> Drowning trauma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Unconscious |
| <input type="checkbox"/> Fainting or blackout | <input type="checkbox"/> Sprains | <input type="checkbox"/> Major wound |
| <input type="checkbox"/> Allergic reaction to a medication? _____ | | |
| What medication(s)? _____ | | |
| What was the allergic reactions? _____ | | |

Please describe your (the client's) condition that led you to seek homeopathic care: _____

What is your first priority for treatment, if possible? _____

Thank you for your patience and thoroughness in completing the above questions. The homeopath works with details of all sorts, to piece together the health puzzle unique to every individual. This information will help us to design an approach to begin working with you or your child as efficiently and effectively as possible.

Please attach a current vaccine record and your chronological historical/medical timeline (see next page for guidance) to this form.

We look forward to working with you and journeying with you to the greatest health potential possible. Thank you!

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