



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? _____

Have you (the client) ever been medically diagnosed with or experienced:

- | | |
|--|---|
| <input type="checkbox"/> Epstein-Barre virus | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heat stroke |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Allergic rhinitis (hay fever) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergic dermatitis | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> Vaccine reactions | <input type="checkbox"/> Attention Deficit Disorder (DD) |
| <input type="checkbox"/> Attention Deficit Hyperactive Disorder (ADHD) | |
| <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Pervasive Developmental Disorder (PDD) |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Urinary tract dysfunction or infection |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Sjogren's Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Reflux disease (GERD) |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Diarrhea (chronic) | <input type="checkbox"/> Constipation (chronic) |
| <input type="checkbox"/> Bloating or gas (chronic) | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Fungal disorders of skin |
| <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Spinal or disc disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sensory Integration Disorders |
| <input type="checkbox"/> Pre-cancerous condition | <input type="checkbox"/> Pregnancy problems |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Difficult, painful periods | <input type="checkbox"/> Hot flashes (related to menopause) |
| <input type="checkbox"/> Pre-Menstrual Syndrome | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal bleeding |
| <input type="checkbox"/> Vaginal irritation/itching | <input type="checkbox"/> Abnormal PAP test |
| <input type="checkbox"/> Fever blister | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Streptococcal infection | <input type="checkbox"/> Staphylococcal infection |
| <input type="checkbox"/> Hypo-thyroidism | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Liver disease |

Have you (the client) 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) child ever been treated by:

- Chiropractor Osteopath (D.O.) Nutritionist

Have you/your child received vaccinations? _____ Please provide a vaccine record, if so.

Did you/your child receive a Hepatitis B vaccination near birth? _____

Was your/your child'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) 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!

Cindy Griffin, DSH-P, D.I.Hom., B.M.Ed.
Lindyl Lanham, DSH-P, B.S. Spec. Ed.
Julie Adams, DSH-P, NST-P, BA (Psych)
Jenice Stebel, DSH-P, D.I.Hom.