HOMEOWORKS PLLC
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Asheville NC 28815

Homeopathic Adult Case-Taking Questionnaire

Name: Last: _____ First: _____ Middle: _____

Address: _____

Telephone: (home) : _____ **(mobile):** _____

Date of Birth: _____ (Month/Date/Year)

Gender (circle one): Male Female Transgender

Weight: ____ **Height**: ____

Marital Status (circle one): Single, Married, Divorced, Domestic Partner

Do you have children? _____ How many? _____

Do you have any food or drug allergies? Yes No

If yes, allergies to what? (include foods and medicines)

Note: While you are completing the questionnaire, please keep in mind your symptom's frequency and strength. For example, do you get headaches only when in the sun, or every day? Is the headache always at 4 PM? Do you get a headache that moves from the back of your head to behind your right eye? Another example is fear of snakes. Do you just have a fear like everyone else seems to, or do you climb on top of the table and scream?

PAST MEDICAL HISTORY

In the list below, check ALL major illnesses you have and on the next page give any relevant details:

Meningitis __	Whooping cough __	Rheumatism __
Diphtheria __	Malaria __	Backache __
Typhoid __	Jaundice __	Ear Infections __
Cholera __	Liver disease ___	Frequent Colds __
Food Poisoning __	Spleen disease __	Sore Throats __
Worms __	Gall Bladder disease __	Sinusitis__
Diarrhea __	Miscarriage __	Bronchitis__
Dysentery ___	Abortion __	Pneumonia __
Measles __	Curettage __	Asthma __
German measles __	Sick when pregnant __	Pleurisy__
Chickenpox __	Uterine Prolapse __	Tuberculosis __
Smallpox __	Malnutrition __	
Mumps __	Rickets __	

Any sexually transmitted diseases, such as: HIV, syphilis, gonorrhea, chlamydia, or Human papilloma virus? How was it treated?

Hypertension? Any other heart conditions or circulatory problems?

Gastrointestinal problems?

Kidney or bladder problems?

Diabetes or diabetic complications?

Any of the following surgeries?

Cataracts __	Appendix __	Gallstones __
Ears __	Hernia __	Phimosis __
Tonsils __	Hemorrhoids __	Hydrocele __
Adenoids __	Uterus __	Other:
Abdomen __	Renal stones __	

Have you had anesthesia: general or local? If yes, what was it for?

Any lumbar punctures? If yes, for what reason?

Chronic headaches, numbness, cramps, spasms, twitching, convulsions, numbness, tingling, or paralysis?

Any major accident or injury to body or head? Explain.

Was there any loss of consciousness?

Any major bleeding from any part of the body?

Do you have a history of frequent colds or flus?

Do you have any discharges post-nasal drip, runny nose?

Did you ever have any childhood diseases more than once?

Did you ever have any skin conditions such as pimples, boils, carbuncles, ringworm, fungus, scabies, eczema, tumors? Where were they? When did you get these treated? How were they treated?

Any other comments?

FAMILY MEDICAL HISTORY

To the best of your knowledge, which diseases exist in your family?

Anemia __	Tuberculosis __	Stroke/Paralysis __
Cancer __	COPD/Emphysema __	Hypertension __
Diabetes __	Leprosy __	Heart trouble __
Depression __	Seizure disorder __	Kidney disease __
Bipolar disorder__	Bleeding disorders __	Liver disease__
Schizophrenia __	Hives __	Other: __
Anxiety __	Eczema __	
Rheumatism __	Asthma __	

Please include whether the family members are alive or deceased, current medical conditions, and/or cause of death. If not known, please mark unknown.

Paternal Grandfather: Paternal Grandmother:

Maternal Grandfather: Maternal Grandmother:

Father: Mother:

Paternal Uncles: Paternal Aunts:

Maternal Uncles: Maternal Aunts:

Do any of your relatives have medical problems similar to yours? If so, who and what?

How many brothers or sisters do you have? (Include those who have died.) If known, what are their ages and current medical conditions?

PERSONAL MEDICAL HISTORY

Prenatal History:
What information do you know about your prenatal history? For instance, did your mother experience any significant mental, emotional, or physical problems while she was pregnant? What was her mood during pregnancy?

What do you know about your birth? Were there any difficulties about your birth? Give details, if possible.

Did your mother have any problem during pregnancy?

Did your mother take legal or illegal drugs during her pregnancy with you? If so, what were they?

Developmental:
Was there any other problem about your growth & development in these areas?

Teething _____	Standing _____
Urine Control _____	Walking _____
Bed-wetting _____	Speaking ____
Sitting _____	

Did you eat chalk, paint, lime, dirt, ice, etc.?

In school, did you have any learning disabilities?

Mark if any animal/insect bites such as:

Dog __	Scorpion __
Cat __	Spider __
Rat __	Other __
Snake __	

Were you given any anti-rabies, anti-venom, or other treatments? If so, which ones?

Vaccinations and Inoculations: Indicate which vaccines you received and the number of times you were vaccinated for the following:

Smallpox	Varicella	Hepatitis B
Polio	B.C.G.	HPV
Cholera	Typhoid	Influenza
MMR	Pneumococcal	Other:
DTP	Tetanus	
Meningococcal	Hepatitis A	

Did you have any particular or severe reaction after any of above vaccinations of inoculations? If so, please be specific and detailed.

If you are in a relationship or are married, what is the health of your significant other/spouse?

If you have children what are you children's name(s), age, and medical condition:

If any of your children are deceased, what was the cause of death?

What are your habits and/or addictions? How much and for how long?

Smoking/Chewing Tobacco/Snuff	Narcotics
Marijuana	Street Drugs
Alcohol	Sedatives
Coffee or Tea	Diet pills
Chocolate	Laxatives
Sex	Any other?

Have you ever been hospitalized? If so, when and for what?

List the number of dental fillings and what types of fillings: amalgam, ceramic, gold, mercury. What dental procedures have you had?

If you are presently taking medications, supplements, vitamins, what are they and what is the dosage?

GENERAL SYMPTOMS

1. What is/are your main complaint(s)?

2. What are the symptoms of your main complaint(s)?

3. Can you trace the origin to any particular accident, illness, incident or mental upset? When did your complaint first occur?

4. Do you experience any particular or unusual sensation? Is so, describe

5. What is the precise location of your complaint?

6. Are there any symptoms that occur at the same time you have another symptom? For example, are your symptoms affected by the weather, by temperature (heat or cold), by movement, certain foods, by light or noise?

7. Are your symptoms worse in the day or night? If so, around what time?

WOMEN

1. At what age did menses start?

2. How frequent do they come?

3. When you have menses, how would you describe duration, abundance, color, at what time is the flow the greatest? Are there any clots? Is there any odor?

4. Do you feel better or worse before, during or after menses?

5. How many pregnancies have you had? Any miscarriages or abortions?

6. Are you experiencing peri-menopausal or menopausal symptoms?

7. Have you had recurrent cystitis?

8. Do you have recurrent vaginal discharges? Please describe color, odor, and consistency.

9. Do you feel better or worse after coition?

MEN

1. Do you have any prostate trouble?

2. Do you have troubles maintaining an erection?

GENERAL QUESTIONS

1. Do you feel like you are a cold or hot person?

2. Are you affected by sudden changes in weather? (for example, hot to cold, walking into a hot room/cold room)

3. Do you feel better in open air?

4. Do you have any reaction to cold, hot, dry, wet or windy weather?

5. Do you have any strong reactions to sudden changes in weather?

6. Do you have any reactions to drafts?

7. Which season bothers you the most?

8. Are you very sensitive to bright sunlight? Do you get headaches in the sunlight?

9. Are you sensitive to noises? Are you sensitive to being touched?

10. Before, during or after a storm, do you have any strong reactions?

11. How do you feel being in the mountains or at the seashore?

12. Do you have any very strong food dislikes or cravings? Are there foods that you refuse to eat or foods that you have to have?

13. Do you experience bloating or distention before, during or after eating?

14. Do you drink adequate fluids during the day? How much and what do you drink?

15. Do you perspire? If so, where? Is there an odor to your perspiration?

16. Do you have any difficulties sleeping?

17. Do you sleep during the day? Do you take naps? How do you feel after a nap?

18. Do you have any nightmares or night terrors?

19. Do you have recurring dreams? Do your dreams have themes?

20. Do you sleep in any particular position?

21. Do you snore, moan, talk, cry, grind your teeth, toss and turn during sleep?

22. How do you feel in the morning when you wake up?

MENTAL/EMOTIONAL

1. Have you experienced any serious griefs, heartbreaks, disappointments, divorces, or frightful events? Have you ever had any emotional, physical or sexual shocks or traumas? If so, could you describe at what age(s) these occurred and what emotions you felt at that time?

2. Do you have any very strong fears or phobias? What are they? (For example: heights, darkness, narrow spaces, snakes, insects, being alone, clowns, etc.)

3. Do you have any irrational jealousy?

4. Do you worry excessively? How do you manage your worries?

5. Are you neater and more organized than most people?

6. Do you have troubles sitting still and focusing?

7. Do you cry easily? Out of the blue? Is it difficult to cry?

8. Have you been depressed in the past? Are you having symptoms of depression? What are they?

9. Have you ever thought of suicidal in your past? Are you currently suicidal?

10. Do you prefer being alone or around people to feel better?

11. Do you keep your emotions inside or do you feel comfortable talking about them?

12. How does music make you feel when you're depressed?

13. Is there any time of the day where you feel better or worse?

14. How would you describe your self-esteem and confidence?

15. What experience(s) have brought you the greatest joy?