

Homeopathic Healing Center

1186 Lincoln Avenue, San Jose, CA 95125

Homeopathic Questionnaire for Adults Male/Female

File# (please leave blank for the HHC to fill out):

First name:

Last name:

Date of Birth (mm/dt/year):

Phone#

Home Address:

Gender (Male/Female):

Main problem symptoms, how and when did it start and for how long the troubling symptoms have been bothering you (describe in your own words without using any medical terms).

Mind symptoms, like any sensations, sleep, dreams, fears, fear of falling, motion, etc.

General symptoms which describe you as a whole, like "I am always hot/sweating", "I love cool/warm air", "I dread nights ,afraid of ghosts, etc including the situations/conditions that make you feel better or worse as a whole.

Modalities - What conditions, foods, weather, times of the day or night, etc make you feel worse or better overall or any of the main symptoms. What kind of foods you like/dislike (also hot, spicy, pungent, sour, sweet, bitter, etc)

Females only:

Menses (late, early, painful, any accompanying symptoms, type of blood, color, strings, etc), leucorrhoea (white discharge), and the overall relation to the worsening or betterment of the symptoms before, during or after the menses.

Any other conditions like warts, growths and abnormal colors of the female parts observed by/bothering you. Also indicate if these cause any discomfort, pain, itching or any other abnormal sensations (please describe in detail):

Are you in the child-bearing age or have reached menopausal age.

Number of children you have?

Any conception problems or sterility:

Was your earlier pregnancy/delivery normal (describe)

Are you pregnant now?

Problems with breasts (pain, swelling, tumors, etc)

Did you have normal quantity of breast milk for the baby(s)?

Any other symptoms that you feel are important to describe;

Males Only

Genitals: Describe any shriveling, growth, tumors, or any other appearance problem:

Sexual desire; Diminished, increased, lost, impotency, erection problem, etc, please describe in detail.

Coitus: Normal, painful or any other conditions, sensations before, during or after.

Masturbation/nocturnal pollutions?

Any other sexual condition that you feel is important for you to describe.

Please describe any problems/symptoms pertaining to the following. Please describe in detail (pain, sensations, conditions that make the symptoms worse/better):

Head:

Eyes

Ears

Nose

Face:

Tongue

Throat

Sinus

Stomach/Abdomen

Skin

Urinary organs

Heart/blood

Endocrine glands like thyroid, pancreas, etc

Locomotor system (Knees, feet, legs, hands, arms, etc.)

Respiratory system (lungs, cough, expectoration type, voice, difficult respiration)

Nervous symptoms: Seizures (with or without auras), paralysis (general or of any parts), insomnia, dreams, restlessness (general or of any parts like legs, etc.), general weakness, alcoholism, involuntary movements of parts, goiter, nervousness, wasting of any limbs, etc, please describe in detail.

Please describe in detail any peculiar and strange symptoms, behavioral patterns, habits or fears (howsoever insignificant/common they may appear to you)

Please describe any mishaps/abuses you may have suffered

Please describe in detail any peculiar and strange symptoms, behavioral patterns, habits or fears of your child that you notice (howsoever insignificant/common they may appear to you)

Please describe any mishaps/abuses you may have suffered

Additional general symptoms:

Please describe if you noticed any change in symptoms, seat of disease (like the skin condition got better but got diarrhea, etc), any personal tragedies, fears or other suppressing conditions that could have contributed to the existing condition.

Did you notice any health changes after any vaccinations/inoculations, etc.

Any other health/mind/emotional information you would like to share:

