

New Patient Questionnaire

Please fill out the following to the best of your knowledge. If you do not know the answer or the question does not apply to you then leave it blank. Email this back to me before your appointment to willow_eb@yahoo.com

Date _____

Name _____

Referred by _____

If child, parent's name

Email _____

Sex _____

Age _____

Date of birth _____

Place of birth _____

Occupation/school grade _____

Address _____

City _____

State _____

Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

(*need at least one phone number)

Please be concise and brief with your answers:

1. Describe your main health concerns in order of importance to you. Describe the symptoms you have with each health concern-its location, character and modalities (what makes the symptom better or worse)
2. What do your symptoms of your main health concern prevent you from doing? What would be the difference if your main concern was cured tomorrow?
3. List all medications prescribed by your doctor over the past two years, when taken, and for what reason. Please include any Homeopathic treatment as well.
4. Describe any stresses that negatively impacted your health and healing over the past two years.
5. Operations, if any, when and what for:
6. Childhood diseases, if any:
7. Vaccinations to which you have had a strong or adverse response. This question is predominately for children or persons who have traveled to other countries where vaccines were required.
8. List all illnesses/diseases you have had since childhood and describe the recovery from each disease/illness.
9. Any condition from which you “have never been well since”
10. Is there anything surrounding your birth that may be important for me to know? (trauma, etc.)

11. Family History: Have your parents, grandparents or other relations had any major diseases or been chronically sick with any particular disease? Hereditary tendencies are important in homeopathy such as mental disease (ie, schizophrenia), alcoholism, cancer, tuberculosis, lung problems, congenital disease, etc.

12. Appetite: Are there any foods that upset your digestion or affect you adversely? Are there any foods that you really don't like eating? Are there any foods that you do like to eat or that you crave? (these can be foods that you crave yet avoid for health reasons)

13. Describe your general body temperature and, if variable, what makes you or any particular area uncomfortable.

14. Sleep patterns: Tell me about the quality of your sleep, if you favor or start out in a particular position; do you wake up in the middle of the night at a certain time, is your sleep disturbed or interrupted, do you feel rested after you wake up, do you feel tired even after you have had a good night's sleep, etc?

15. Describe what stands out about your perspiration patterns, especially if under certain circumstances or if it is notable on particular areas of your body.

16. Women: Describe your menstrual patterns in terms of quality and length of flow, cycle frequency, clotting or heavy cycles, the nature of any pain and at which point in your cycle it appears, etc. Include the age at which you first menstruated and if you experienced problems at that time. Describe all forms of birth control, including any adverse reactions. If you no longer have a menstrual cycle then please describe what your menses was like and any menopausal symptoms you may have or have already had if that is the case.

17. Describe current or past skin eruptions and treatments. Include warts, moles, and any skin cancer.

18. Describe your current and past dental health.

19. Please add anything else you would like to mention.