Janine Maere, MD 211 Landmark Dr.

309-268-9304 Office Suite E1

309-268-9626 Fax Normal, IL 61761

Comprehensive Health History Questionnaire

IMPORTANT: Please complete this document as thoroughly as possible. Some of the  questions that follow may seem unrelated to your condition, but they may play a major role  in diagnosis and treatment. All information is strictly confidential.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (last, first, MI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     State:\_\_\_\_\_\_\_     Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Sex:  Female/ Male

Marital Status (circle one): Married/ Single/ Divorced/ Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Health Care Physician/MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If referred, please give the name of who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had acupuncture before: Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a Homeopath before? Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker or other implantable device: Yes No

What is the primary reason(s) for your visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the onset (circle one):     Sudden     Gradual

What medical diagnosis have you received for this condition (if any):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other treatments have you received for this condition:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medication(s) are you taking for your primary condition, if any:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything relieve or aggravate the condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History

Please check any of the following medical conditions you may have had or currently have by  marking a ‘P” for past condition and a ‘C’ for current condition. If past condition please  indicate when you had it.

\_\_\_\_\_\_\_ AIDS/HIV   \_\_\_\_\_\_\_ Fibromyalgia   \_\_\_\_\_\_\_ Multiple Sclerosis

\_\_\_\_\_\_\_ Alcoholism  \_\_\_\_\_\_\_ Drug Addiction   \_\_\_\_\_\_\_ Heart Disease

\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_ Stroke   \_\_\_\_\_\_\_ Polio

\_\_\_\_\_\_\_ Scarlet Fever   \_\_\_\_\_\_\_ Tuberculosis  \_\_\_\_\_\_\_ Jaundice

\_\_\_\_\_\_\_ Allergies(food, latex) \_\_\_\_\_\_\_ Rheumatic Fever  \_\_\_\_\_\_\_ Pneumonia

\_\_\_\_\_\_\_ Seasonal Allergies \_\_\_\_\_\_\_\_ Asthma     \_\_\_\_\_\_\_ Hepatitis

\_\_\_\_\_\_\_ Seizures/Epilepsy  \_\_\_\_\_\_\_ Migraines  \_\_\_\_\_\_\_ Birth Trauma

\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_ Joint Replacements  \_\_\_\_\_\_\_ Diabetes

\_\_\_\_\_\_\_ Anemia  \_\_\_\_\_\_\_ Thyroid Disorder  \_\_\_\_\_\_\_ Lyme’s Disease

\_\_\_\_\_\_\_ Emphysema    \_\_\_\_\_\_\_ Bleeding Disorder  \_\_\_\_\_\_\_ Mono

\_\_\_\_\_\_\_ Chicken Pox \_\_\_\_\_\_\_ Cold Sores \_\_\_\_\_\_\_ STD

\_\_\_\_\_\_\_ Emphysema \_\_\_\_\_\_\_ Other Lung illnesses \_\_\_\_\_\_\_ Other Liver illnesses

\_\_\_\_\_\_\_ Other Heart illnesses  \_\_\_\_\_\_\_ Other Kidney illnesses

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major injuries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What vaccinations have you had: \_\_\_\_\_ Tetanus- Date:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Shingles- Date:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Pneumonia- Date:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Meningitis- Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Gardisil- Dates:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Chicken Pox -Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Hepatitis B- Dates:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Hepatits A- Dates:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_MMR- Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any adverse reactions to them? Please list information below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History

Please list any major surgeries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and Supplements

Please list all prescribed and over the counter medications, supplements, and vitamins you  are currently taking routinely. Indicate the dosage and reason for taking, as well. Write on the back of the sheets if needed.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_ purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_   purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_    purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_  purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies

Are you allergic to any medications : Y / N

Are you allergic to any supplements/herbs: Y / N

Are you allergic to any food: Y / N

Are you allergic anything in the environment: Y / N

Are you allergic to anything else: Y / N

If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

Relative Alive Health Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother Y / N

Father Y / N

MGF Y / N

MGM Y / N

PGF Y / N

PGM Y / N

Sister Y / N

Brother Y / N

Other Y / N

Birth History

Did you or your mother have any problems during pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did she use any medication/drugs during pregnancy? Y / N

If so what were they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any difficulties with your birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you start:

Teething:

Walking:

Sitting:

Speaking:

Standing:

Urination Control/Bed Wetting:

Were there any other problems about your growth and development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise & Energy

How is your energy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When is your energy the:  Highest? \_\_\_\_\_\_\_\_\_\_\_\_\_ Lowest?    \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you fatigue easily: Y / N

How often do you exercise:  \_\_\_\_\_\_\_times/week  \_\_\_\_\_\_\_\_\_mins/workout

Emotions & Sleep

How do you feel emotionally: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: (check all that apply)

\_\_\_\_\_\_ Panic attacks  \_\_\_\_\_\_ Anxiety  \_\_\_\_\_\_ Depression   \_\_\_\_\_\_ Mania

\_\_\_\_\_\_ Bad temper / Anger  \_\_\_\_\_\_ Poor memory \_\_\_\_\_\_ Worry

\_\_\_\_\_\_ Overthinking  \_\_\_\_\_\_ Difficult Concentrating

How high is your stress level currently (circle one):

Mild (1‐3/10)     Moderate (4‐6/10)      Severe (7‐8/10)      Uncontrolable (9‐10/10)

How do you carry your stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you try to relax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you sleep: \_\_\_\_\_\_\_\_hours/night     Do you feel refreshed up waking: Y / N

I have difficulties with: (check all that apply):   \_\_\_\_\_ Falling asleep   \_\_\_\_\_ Staying asleep

\_\_\_\_\_ Dream‐disturbed \_\_\_\_\_ Insomnia \_\_\_\_\_ Sleep Apnea    \_\_\_\_\_ Snoring

\_\_\_\_\_ Restlessness

Do you take any sleep aids: Y / N

If so, which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal Symptoms

Do you experience(check all that apply): \_\_\_\_\_ Belching   \_\_\_\_\_ Nausea/Vomiting

\_\_\_\_\_ Ulcers \_\_\_\_\_ Bloating   \_\_\_\_\_ Heartburn  \_\_\_\_\_ Acid regurgitation

\_\_\_\_\_ Hernia   \_\_\_\_\_ Indigestion   \_\_\_\_\_ Stomach Pain  \_\_\_\_ Lack of Appetite

\_\_\_\_\_ Increased Appetite    \_\_\_\_\_ Crohns Disease  \_\_\_\_\_ Celiac Disease

\_\_\_\_\_ Ulcerative Colitis  \_\_\_\_\_ Cramping  \_\_\_\_\_ Incomplete Emptying

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel Movements

How often: \_\_\_\_\_\_\_times/day    \_\_\_\_\_\_\_\_\_\_ days/week

I have(check all that apply):   \_\_\_\_\_ Constipation   \_\_\_\_\_ Diarrhea   \_\_\_\_\_ Gas

\_\_\_\_\_ Irregular bowel movements   \_\_\_\_\_Burning sensation   \_\_\_\_\_ Hemorrhoids

\_\_\_\_\_ Undigested food in stool  \_\_\_\_\_ Loose Stool    \_\_\_\_\_ Hard stool

\_\_\_\_\_ Blood in stool   \_\_\_\_\_ Painful bowel movements   \_\_\_\_\_ IBS

Any abnormal color to stools:  Y / N    Any abnormal odor to stools: Y / N

Urinary Symptoms

How often do you urinate: \_\_\_\_\_\_times/day

Color: \_\_\_\_\_ Pale yellow    \_\_\_\_\_ Dark yellow/orange  \_\_\_\_\_ Clear  \_\_\_\_\_ Cloudy

I have(check all that apply):

\_\_\_\_\_ Trouble starting stream   \_\_\_\_\_Frequent urination

\_\_\_\_\_ Scanty  \_\_\_\_\_ Incontinence   \_\_\_\_\_ Pain/Burning

\_\_\_\_\_ Blood in urine  \_\_\_\_\_ Kidney stones \_\_\_\_\_ UTI

\_\_\_\_\_ Bladder Infection  \_\_\_\_\_ Nighttime Urination

Do you drink water throughout the day?  Y/ N    Average, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female G.U.

At what age did you start menstruating: \_\_\_\_\_\_\_\_\_\_  How many days is your cycle: \_\_\_\_

Number of days of flow: \_\_\_\_\_\_\_\_\_\_  Clots: Y / N

Do you get PMS: Y / N  If yes, what symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have (check all that apply):

\_\_\_\_\_ Irregularity    \_\_\_\_\_ Heavy flow    \_\_\_\_\_ Light/ No flow

\_\_\_\_\_ Itching/burning   \_\_\_\_\_Spotting   \_\_\_\_\_Discomfort/ Pain

Vaginal discharge:  Y / N  If yes, what color:            Any Odor: Y / N

Do you have any children: Y / N  If yes, how many:           Natural / C‐Section

Miscarriages:  Y / N     How many?      Abortions:  Y / N      How many?

Menopause: Y / N    When: \_\_\_\_\_\_\_    Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please fill out the following menstrual chart: | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Color (normal, bright red, pale, rust, brown, |  |  |  |  |  |  |  |
| dark, purple, other) |  |  |  |  |  |  |  |
| Amount of Flow (normal, heavy, light) |  |  |  |  |  |  |  |
| Pain/Cramps (location, dull, sharp, other) |  |  |  |  |  |  |  |
| Clots (large, small, black, red, purple, other) |  |  |  |  |  |  |  |
| Vomiting (check if yes) |  |  |  |  |  |  |  |
| Nausea (check if yes) |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

Male G.U.

I have (check all that apply):

\_\_\_\_\_ Prostatitis   \_\_\_\_\_ Impotence   \_\_\_\_\_ Abnormal Discharge

\_\_\_\_\_ Enlarged Prostate   \_\_\_\_\_ Low/High Libido   \_\_\_\_\_ ED

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscles, Joints & Bones

Do you have pain or tightness: Y / N  Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The pain is:

\_\_\_\_\_ Sharp   \_\_\_\_\_ Dull   \_\_\_\_\_ Aching  \_\_\_\_\_ Numbing   \_\_\_\_\_ Superficial

\_\_\_\_\_ Deep   \_\_\_\_\_ Burning \_\_\_\_\_ Tingling   \_\_\_\_\_ Shooting

\_\_\_\_\_ Pain worse/better with heat       \_\_\_\_\_ Pain worse/better with cold

\_\_\_\_\_ Pain worse/better with pressure    \_\_\_\_\_ Pain worse in am/pm

I have (check all that apply):

\_\_\_\_\_ Swollen joints   \_\_\_\_\_ Arthritis/joint pain   \_\_\_\_\_ Tendonitis

\_\_\_\_\_ Bone pain   \_\_\_\_\_ Muscle cramping   \_\_\_\_\_ Muscle pain

\_\_\_\_\_ Repetitive Injury

\_\_\_\_\_ Fractured Bone(s):    Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiovascular

When was the last time your blood pressure was taken: \_\_\_\_\_\_\_\_\_\_  What was it: \_\_\_\_\_\_\_\_\_

I have (check all that apply):

\_\_\_\_\_ Chest pain    \_\_\_\_\_ Palpitation    \_\_\_\_\_ Varicose Veins   \_\_\_\_\_ Blood Clots

\_\_\_\_\_ Irregular Heart Beat   \_\_\_\_\_ Poor circulation   \_\_\_\_\_ Hypertension

\_\_\_\_\_ Hypotension   \_\_\_\_\_ Raynaud’s   \_\_\_\_\_ Arteriosclerosis \_\_\_\_\_ Breathlessness

If you checked Hyper/Hypotension, is it being controlled:  Y / N

Are you currently taking blood thinners:  Y / N

Neurological

Have you or do you currently experiencing (check all that apply):

\_\_\_\_\_ Tremors \_\_\_\_\_ Numbness or tingling  \_\_\_\_\_ Paralysis

\_\_\_\_\_ Brain disorder/damage  \_\_\_\_\_ Poor memory \_\_\_\_\_ Poor balance

\_\_\_\_\_ Parkinson’s \_\_\_\_\_ Bell’s palsy  \_\_\_\_\_ Trigeminal Neuralgia

\_\_\_\_\_ Shingles  \_\_\_\_\_ Peripheral neuropathy  \_\_\_\_\_ Restless leg syndrome

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head                                                                               Headaches:  Y / N   location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the pain travel: Y / N Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity:      Mild (1‐3/10)    Moderate (4‐6/10)    Severe (7‐10/10)

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you believe your headaches to be migraines?  Y / N

If yes, do you experience:  \_\_\_\_\_auras \_\_\_\_\_nausea \_\_\_\_\_\_light sensitivity

Do you or have you experienced:

\_\_\_\_\_ Dizziness     \_\_\_\_\_ Vertigo     \_\_\_\_\_ Fainting     \_\_\_\_\_ Lack of Concentration

\_\_\_\_\_ Mental Fogginess

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyes

Do you wear glasses or contacts:  Y / N

Do you have (check all that apply):

\_\_\_\_\_ Blurry Vision \_\_\_\_\_Double vision \_\_\_\_\_ Dryness  \_\_\_\_\_ Floaters

\_\_\_\_\_ Near sighted  \_\_\_\_\_ Tearing       \_\_\_\_\_ Itching         \_\_\_\_\_ Redness

\_\_\_\_\_ Far sighted   \_\_\_\_\_ Cataracts      \_\_\_\_\_ Glaucoma  \_\_\_\_\_ Burning

\_\_\_\_\_ Poor Night Vision

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ears

Do you have ringing of the ears:  Y / N    If so, is it the:  R / L / Both Ear(s)

Is the ringing:  Constant / comes & goes  Is pitch: Low / High      Started: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have:  \_\_\_\_\_ Earache(s)     \_\_\_\_\_ Meniere’s Disease \_\_\_\_\_ Pressure/Clogged

\_\_\_\_\_ Deafness    If so, is it the: R / L / Both Ear(s)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nose

Do you have (check all that apply):

\_\_\_\_\_ Nasal congestion  \_\_\_\_\_ Sneezing  \_\_\_\_\_ Sinus infections (chronic / acute)

\_\_\_\_\_ Discharge  If so, color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Loss of sense of smell \_\_\_\_\_ Deviated septum   \_\_\_\_\_ Chronic nosebleeds

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mouth & Throat

Do you have (check all that apply):

\_\_\_\_\_ Thirst/dryness   \_\_\_\_\_ Sore throat  \_\_\_\_\_ Cough

\_\_\_\_\_ Bad taste in mouth  \_\_\_\_\_ Canker sores   \_\_\_\_\_ Cold Sores

\_\_\_\_\_ Loss of taste       \_\_\_\_\_ TMJ/Jaw pain \_\_\_\_\_ Bad breath

\_\_\_\_\_ Bleeding gums      \_\_\_\_\_ Hoarseness  \_\_\_\_\_ Voice Change

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin & Hair

I have (check all that apply):

\_\_\_\_\_ Dryness  \_\_\_\_\_ Skin rashes   \_\_\_\_\_ Itching   \_\_\_\_\_ Acne

\_\_\_\_\_ Eczema   \_\_\_\_\_ Psoriasis  \_\_\_\_\_ Changes in Moles  \_\_\_\_\_ Hives

\_\_\_\_\_ Hair loss  \_\_\_\_\_ Thinning of Hair   \_\_\_\_\_ Premature graying  \_\_\_\_\_ Edema

Do you bruise easily:  Y / N

Sweating:  Zero‐Minimal / Normal / Excessive

Do you have:   Cold Hands / Feet    Hot Hands / Feet  Whole Body Heat / Coldness

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet & Lifestyle

My diet consists mostly of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeine:  Y / N     how much: \_\_\_\_\_\_\_\_\_  coffee / tea / soda/ energy drinks

Do you drink alcohol:  Y / N       how much: \_\_\_\_\_\_\_\_\_

Do you smoke: Y / N      how much: \_\_\_\_\_\_\_\_\_

Do you chew tobacco: Y / N how much: \_\_\_\_\_\_\_\_\_\_

Do you do recreational drugs: Y / N which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat spicy foods: Y / N    Do eat dairy: Y / N  Do you eat meat: Y / N

Do you have cravings: Y / N For what ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you prefer warm or cold foods? warm / cold

Do you prefer warm or cold drinks? warm / cold

Does your body feel heavy or dragging:  Y / N

Do you notice a significant change in your body temperature recently:  Y / N

If so:  Hot / Cold

Do you often get sick?   Y / N

Recent change in weight:  Y/ N  intentional?  Y / N

Instructions for Homeopathic Intake Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may help determine which homeopathic remedy is best suited for you. All information in this questionnaire is kept confidential.

The questionnaire is designed to be user friendly. You can answer many of the questions by placing a circle around the appropriate number. For example:

Which weather conditions are you most troubled by? Circling a number closer to the clear end means that you are more troubled by clear weather. Circling a number closer to the cloudy end means that you are troubled by cloudy weather. Cloudy 1 2 3 4 5 6 7 8 9 10 Clear

Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. Circling number “1” means that you are troubled very little while marking “10” means that you are troubled a lot. For example:

Do you worry about any of the following? Circling closer to “10” means that you worry about your health a lot. Circling closer to “1” means that you do not worry about your health.

1 2 3 4 5 6 7 8 9 10 Health

Some questions ask you to circle the answer you think best fits you. For example:

What are your feelings toward disease? Optimistic Doubtful of Recovery Fearful

Despair of Recovery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following general symptoms pertain to you as a whole person. Which weather conditions are you most troubled by?

Cloudy 1 2 3 4 5 6 7 8 9 10 Clear

Wet 1 2 3 4 5 6 7 8 9 10 Dry

Damp cold 1 2 3 4 5 6 7 8 9 10 Snow (Dry Cold)

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble? Winter Spring Fall Summer

Are you worse being in the:

Mountains 1 2 3 4 5 6 7 8 9 10 At the seashore

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

Are you generally chilly or warm?

Chilly 1 2 3 4 5 6 7 8 9 10 Warm

Which are you generally most sensitive to, warm or cold?

Cold 1 2 3 4 5 6 7 8 9 10 Warm

What times of day are you generally worst (mood, energy, symptoms, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What times are you best? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms during sleep. Circle which you have:

Tooth Grinding Restlessness Talking Perspiration Frequent Urination

Excess Heat or Cold Laughing Snoring Nightmares Recurring Dreams

Sleepwalking

Circle what you prefer. Do you sleep:

Without Covers Partly Covered Fully Covered (Not including Head)

Fully Covered (Including Head) With Arms or Legs Out of the Covers

Without Clothing With a Fan or Air Blowing on You With the Window open

What position do you sleep in most often?

Right Side On Back Left Side On Abdomen

How much do you perspire? Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you have difficulty waking? Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you wake unrefreshed? Never 1 2 3 4 5 6 7 8 9 10 All the Time

Food Desires and Aversions: In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1. Tastes:

1 2 3 4 5 6 7 8 9 10 Sweet

1 2 3 4 5 6 7 8 9 10 Sour

1 2 3 4 5 6 7 8 9 10 Salty

1 2 3 4 5 6 7 8 9 10 Bitter

1 2 3 4 5 6 7 8 9 10 Spicy (hot)

1 2 3 4 5 6 7 8 9 10 Smoked

1 2 3 4 5 6 7 8 9 10 Juicy

1 2 3 4 5 6 7 8 9 10 Refreshing

1 2 3 4 5 6 7 8 9 10 Pungent

1 2 3 4 5 6 7 8 9 10 Alcohol

1 2 3 4 5 6 7 8 9 10 Apples

1 2 3 4 5 6 7 8 9 10 Bacon

1 2 3 4 5 6 7 8 9 10 Bread alone

1 2 3 4 5 6 7 8 9 10 Bread with butter

1 2 3 4 5 6 7 8 9 10 Butter alone

1 2 3 4 5 6 7 8 9 10 Cheese

1 2 3 4 5 6 7 8 9 10 Chocolate

1 2 3 4 5 6 7 8 9 10 Coffee

1 2 3 4 5 6 7 8 9 10 Pastries

1 2 3 4 5 6 7 8 9 10 Eggs

1 2 3 4 5 6 7 8 9 10 Fat (meat, chicken, pork,etc.)

1 2 3 4 5 6 7 8 9 10 Fish

1 2 3 4 5 6 7 8 9 10 Fruit

1 2 3 4 5 6 7 8 9 10 Fruit (sour)

1 2 3 4 5 6 7 8 9 10 Grain products (pasta, bread, cereal, etc.)

1 2 3 4 5 6 7 8 9 10 Ham

1 2 3 4 5 6 7 8 9 10 Ice

1 2 3 4 5 6 7 8 9 10 Ice cream

1 2 3 4 5 6 7 8 9 10 Indigestible things (chalk, clay, paper, etc.)

1 2 3 4 5 6 7 8 9 10 Lemonade

1 2 3 4 5 6 7 8 9 10 Meat

1 2 3 4 5 6 7 8 9 10 Milk

1 2 3 4 5 6 7 8 9 10 Nut butters

1 2 3 4 5 6 7 8 9 10 Oysters

1 2 3 4 5 6 7 8 9 10 Pickles

1 2 3 4 5 6 7 8 9 10 Vegetables

1 2 3 4 5 6 7 8 9 10 Vinegar

Temperature of food. Which do you prefer?

Warm Food 1 2 3 4 5 6 7 8 9 10 Cold Food

Warm Drinks 1 2 3 4 5 6 7 8 9 10 Cold Drinks

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How thirsty are you generally? Not at all 1 2 3 4 5 6 7 8 9 10 Very

Mental and Emotional State: How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

Do you worry about any of the following? 10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

Answer as honestly as you can about your personality traits.

Frightened Easily 1 2 3 4 5 6 7 8 9 10 Never Afraid

Stingy 1 2 3 4 5 6 7 8 9 10 Overly generous

Thrifty 1 2 3 4 5 6 7 8 9 10 Extravagant

Hurried, impatient 1 2 3 4 5 6 7 8 9 10 Slow

Messy 1 2 3 4 5 6 7 8 9 10 Fastidious

Calm 1 2 3 4 5 6 7 8 9 10 Restlessness

Indolence (Lazy) 1 2 3 4 5 6 7 8 9 10 Always busy

Shyness/Timid/Bashful 1 2 3 4 5 6 7 8 9 10 Outgoing

Anger 1 2 3 4 5 6 7 8 9 10 Mildness

Lack of moral sense 1 2 3 4 5 6 7 8 9 10 Guilty

No Religious feeling 1 2 3 4 5 6 7 8 9 10 Highly Religious Feeling

Obstinate (stubborn) 1 2 3 4 5 6 7 8 9 10 Yielding

Heedless/Reckless 1 2 3 4 5 6 7 8 9 10 Cowardice

Social 1 2 3 4 5 6 7 8 9 10 Antisocial

In regard to being with other people or in company?

Aversion 1 2 3 4 5 6 7 8 9 10 Desire for

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Dwells on Inconsolable Remorse Guilt

Feeling towards people close to you:

Loving Affectionate Indifferent Resentment Hatred

Feeling toward disease/condition:

Optimistic Doubtful of recovery Discouraged Fearful Indifferent

Bored Weary of life Loathing of life Desires death

Suicidal thoughts

Feeling toward spouse/lover:

Loving Affectionate Dissatisfaction Disappointed Indifferent

Resentment Hatred

How much do you have the following symptoms? 10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

1 2 3 4 5 6 7 8 9 10 Mood

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Alternating Moods 1 2 3 4 5 6 7 8 9 10 Even Moods

Not trusting 1 2 3 4 5 6 7 8 9 10 Trusting

Gullible 1 2 3 4 5 6 7 8 9 10 Suspicious

Circle which best expresses your general mood.

Morose Sad Apathy/Indifferent Excitement Exhilaration

How do you experience sympathy or consolation?

Always 1 2 3 4 5 6 7 8 9 10 Never

How talkative are you in general?

Aversion to talking 1 2 3 4 5 6 7 8 9 10 Talkative

How often and easily do you weep?

Never 1 2 3 4 5 6 7 8 9 10 Always

How often do you experience clairvoyance?

Never 1 2 3 4 5 6 7 8 9 10 Always

How is your level of self-confidence?

Lack of confidence 1 2 3 4 5 6 7 8 9 10 Pride/Haughty

How impulsive are you?

Never 1 2 3 4 5 6 7 8 9 10 Always

How afraid are you of the following? 1, never. 10, very afraid.

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative’s Death

1 2 3 4 5 6 7 8 9 10 Impending Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Failure

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/ Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 That something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorms

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

Are you forgetful of any of the following? (1 not at all, 10 a lot)

1 2 3 4 5 6 7 8 9 10 Dates

1 2 3 4 5 6 7 8 9 10 Names

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Of what someone else just said to you

1 2 3 4 5 6 7 8 9 10 Of what you just said

1 2 3 4 5 6 7 8 9 10 Of words

How often do you make mistakes with the following?

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Words (reading)

1 2 3 4 5 6 7 8 9 10 Words (speaking)

1 2 3 4 5 6 7 8 9 10 Words (writing)

How sensitive are you to any of the following?

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

How do you handle conflict usually?

Quarrelsome 1 2 3 4 5 6 7 8 9 10 Yielding

How are you in regard to authority?

Bossy/Dictatorial 1 2 3 4 5 6 7 8 9 10 Yielding/Fawning

How critical are you of others?

Not at All 1 2 3 4 5 6 7 8 9 10 All the Time

How critical are you of yourself?

Not at All 1 2 3 4 5 6 7 8 9 10 All the Time

How often do you reproach (find fault, scold, or blame) others?

Not at All 1 2 3 4 5 6 7 8 9 10 All the Time

How often do you reproach yourself?

Not at All 1 2 3 4 5 6 7 8 9 10 All the Time

How honest are you?

Always Lie 1 2 3 4 5 6 7 8 9 10 Always honest

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary (Opposite to what is logically expected)

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

How often do you have desire to have sex?

Never 1x/year 1x/3 mo. 1x/mo. 2x/mo. 1x/wk. 2x/wk. 4x/wk. 1x/day 2x/day 4x/day

How often do you actually have sex?

Never 1x/year 1x/3 mo. 1x/mo. 2x/mo. 1x/wk. 2x/wk. 4x/wk. 1x/day 2x/day 4x/day

How often do you masturbate?

Never 1x/year 1x/3 mo. 1x/mo. 2x/mo. 1x/wk. 2x/wk. 4x/wk. 1x/day 2x/day 4x/day

What worries or concerns do you have about your sexual life?

Not enough desire 1 2 3 4 5 6 7 8 9 10 Too much desire

Not enough sex 1 2 3 4 5 6 7 8 9 10 Too much sex

1 2 3 4 5 6 7 8 9 10 Lack of enjoyment

1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm

1 2 3 4 5 6 7 8 9 10 Impotence

1 2 3 4 5 6 7 8 9 10 Troubling fantasies or thoughts

1 2 3 4 5 6 7 8 9 10 Sexual confidence

1 2 3 4 5 6 7 8 9 10 Unusual sexual practices or desires

I certify that all the above information is correct and I have listed all of my medical issues,  concerns, previous and current diagnoses, and physical and emotional complaints to the best of my ability. Ohm Energy Medicine and Janine Maere MD are not responsible for the  aggravation of any conditions which were present but weren’t disclosed to the practitioner at the  time of treatment.  I take responsibility to inform my acupuncture practitioner if there are any changes to my  physical, psychological, and emotional state.

Please sign X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_