

Sacred Beings Holistic Healthcare

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Please fill out this form and fax, send or email it to me at least 2 days prior to our appointment. Please use extra paper if you need more space.

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (home) (work) (cell) (fax)
Email Address: _____

Referred by _____ Phone: _____
Family Medical Doctor
Other Primary Care Givers
In Emergency Notify: _____ Phone: _____ Relationship: _____
Insurance Company: _____

The following information is confidential and can only be released with your authorization.

Personal Profile and Health History

DOB/Age: _____ Sex: _____ Marital Status: _____
Height: _____ Present Weight: _____ Goal (normal) Weight: _____
Average or Typical Blood Pressure: _____
Blood Type (if known): _____
Allergies: _____

1. Please list all food supplements/vitamins/herbs that you are currently taking including the doses of each.

2. Please list all prescription drugs you are taking including how long you have been on them.

3. How many times have you been prescribed antibiotics over the last 10 years? _____
Were you ever on antibiotics for an extended period of time? Please explain when and for how long.

Have you used probiotics ("friendly" microflora) following antibiotic use?
Always_____ Often_____ Occasionally_____ Never_____

4. Occupation (Nature of Work) :

5. Average # of hours worked in a week:

6. Stress Level:

7. Diet: Non-Vegetarian Vegetarian For how long?

8. Food Allergies/Intolerances:

9. Environmental Allergies/Sensitivities:

10. Sensitivites to medicines/herbs/vitamins:

General Questions

1. What is your primary health concern or main health complaint?

2. How long have you had this condition?

3. What is your medical diagnosis?

4. Name of the physician who made the diagnosis?

5. When was the diagnosis made?

6. What specialists have you seen?

7. How has this condition been treated until now?

8. Please give a detailed history of your **main complaint** from when you were first aware there was a health problem through to the present. If you can please include dates or a timeline.

9. Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain.

10. What aggravates the main complaint (foods, weather, time of day, movement, light, noise, heat/cold, try and be specific).

11. What symptoms accompany the main complaint?

Additional Health Concerns and Health Goals

12. What else would you like to see changed in your health? List all other health concerns or health goals in order of importance to you. If possible, indicate the month and year each particular health concern started . Also list any specific health goals would you like help with?

13. How long has it been since you experienced excellent health?

14. Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have been given.

In the lists below, circle or X all major illnesses that you currently have been diagnosed with or have experienced.

Childhood Illnesses

Measles (Rubeola)

Mononucleosis

Whooping Cough

German Measles (Rubella)

Mumps

Polio

Chicken Pox

Scarlet Fever

Reye's Syndrome

Gastrointestinal

Colitis
Diverticulitis
Diarrhea
Hemorrhoids
Spleen Disease
Pancreatic Disease

Irritable Bowel Syndrome
Hiatal Hernia
Dysentery
Stomach/Duodenum Ulcers
Gall Bladder Disease
Hepatitis

Crohn's Disease
Constipation

Appendicitis
Jaundice
Other Liver Disease

Sexually Transmitted Disease

Gonorrhea
HIV
Human Papillomavirus (HPV)

Chlamydia
Genital Herpes

Syphilis
Genital Warts

Skin & Hair

Acne
Carbuncles
Scabies
Eczema
Warts
Urticaria (skin allergy)
Skin Cancer
Other

Boils
Ringworm
Shingles
Keloids
Herpes
Ulcers on any part of the body
Hair Loss

Impetigo
Fungus
Poison Ivy
Psoriasis

Musculoskeletal

Rheumatoid Arthritis
Back Pain/Sciatica
Osteoporosis

Osteoarthritis
Fibromyalgia

Rheumatism
Muscle Cramps/spasms

Genito-Urinary

Pain
Increase in urine
Waking up to Urinate

Incontinence
Decrease in Urine
Frequent Urination

Kidney Stones
Blood in Urine
Prostate Problems

Ear, Eye, Nose and Throat

Eye Problem
Tonsillitis
Allergies (environmental)

Strep Throat
Sinusitis
Hay Fever

Scarlet Fever

Cardiovascular

Bronchitis
Pleurisy
Circulation Problems
Fainting
Varicose Veins
Raynaud's Disease

Pneumonia
Tuberculosis
High Blood Pressure
Palpitations
Stroke

Asthma
Heart Problems
Low Blood Pressure
Anemia
Platelet Disorders

Pregnancy & Gynecology

Menopause

Fibrocystic Breast Disease

Vaginitis (recurrent)

Infertility

Preeclampsia

PMS

Uterine Fibroids

Yeast

Uterine Prolapse

Other Pregnancy Illness

Ovarian Cyst

Endometriosis

Painful Periods

Gestational Diabetes

Other

Typhoid

Malnutrition

Diabetes

Cholera

Rickets

Hypoglycemia

Malaria

Gout

Multiple Sclerosis

Migraine Headaches

Cramps

Cushing's Disease

Hyperthyroid (thyroiditis)

Chronic Fatigue

Syndrome)

Lupus

Dizziness (vertigo)

Epilepsy

Addison's Disease

Cancer (specify type)

Environmental Illness

Myasthenia Gravis

Numbness

Meningitis

Hypothyroid

Candida (Yeast

Psychological Disorders

Eating Disorder

Clinical Depression

Other:

Schizophrenia

Suicidal Tendencies

Bipolar Disease

15. In the lists below all surgeries, accidents or traumatic events you have experienced (including treatment required).

Surgeries:**Accidents:**

Any major accident or injury to the body or head.

Any occasion of unconsciousness.

Any hemorrhage or major bleeding from any part of the body.

Trauma:

Any serious shock, grief, major disappointments, severe fright, nervous breakdown, period of stress overload. Briefly describe:

16. Immunizations:

Type	Small Pox	Polio	Meningitis	MMR	DPT	Other	
How many times							
Type	BCG	Typhoid	Tetanus	Hepatitis	Flu	Hib	Cholera
How many times							

Was there any serious reaction to any of the above vaccinations? (Please explain)

17. Dental Work

How many silver amalgam fillings do you have? _____ How many root canals? _____

18. Family History

Please put an "L" for living and a "D" for deceased. Age is present age or age at the time of death.

Relationship L/D Age Diseases Suffered / Cause of Death

- Paternal Grandfather
- Paternal Grandmother
- Maternal Grandfather
- Maternal Grandmother
- Father
- Mother
- Paternal Uncles
- Paternal Aunts
- Maternal Uncles
- Maternal Aunts
- Brother/Sister (1)
- (2)
- (3)
- (4)

How many brothers and sisters? Brothers _____ Sisters _____
What is your position in the family? (oldest, middle, youngest etc.)

Briefly describe the nature of your relationship with your parents? (as a child and as an adult)

How is the health of your spouse or partner?

Number of children living and deceased. Living ____ Deceased ____ (state cause of death)

19. Personal Habits and Lifestyle

1. How many cups/bottles/glasses do you drink on the average per day?

Coffee _____ Tea _____ Water _____ Milk 2% _____ Milk (skim) _____

Fruit Juice _____ Soft Drinks (diet) _____ Soft Drinks (reg.) _____

Vegetable Juice _____ Herbal Tea _____ Beer _____ Wine _____ Liquor _____

2. What is the source of your drinking water?

Tap (city) _____ Well _____ Bottled (spring) _____ Filtered _____ Distilled _____

3. Do you use tobacco products? Y/N

If yes, please circle the products you use and indicate on the line beside them how often you use them. Cigarettes _____ Cigars _____ Chewing Tobacco _____ Snuff _____

4. Have you smoked in the past? Y/N If yes, for how long? _____

5. Does anyone in your household smoke? Y/N

6. Have you ever used nonprescription, mood altering drugs ("recreational" drugs)? -----
If yes, please indicate type, frequency and duration of use.

7. Do you regularly use (please circle) Laxatives, Sleeping Pills, Antacids, Pain Killers

If so, please indicate the type, frequency and amount.

8. How frequently do you move your bowels? _____(number of movements) Daily/Weekly

9. Have you ever had a problem with an addiction? If yes please specify.

Food _____ Alcohol _____ Drugs _____ Other _____

10. How would you describe your present level of personal stress?

Minimal _____ Average _____ Considerable _____ Unbearable _____

11. What is the main stressor?

Financial _____ Job Related _____ Interpersonal _____ Marriage _____
Health _____ Expectations _____ Family Members _____ Spiritual _____

20. Weather & Environment

1. In which season does weather bother you the most?

2. How are you affected by weather? (cold, dry, windy, hot, damp)

3. How do you change of weather and season affect you?

4. How do you react in storms (thunder, lightning etc.)?

5. How do you react to bright sunlight?

6. How do you feel in open air? How do drafts affect you?

7. Do you have any special reactions to moonlight or a full moon?

8. How do you feel by the ocean or in the mountains?

9. Which times of day are better and/or worse for you, or which do you prefer, why?
10. Are you sensitive to strong smells and odors (ie: perfume, tobacco).
11. What is your most comfortable position? And, which position do you dislike the most? (sitting, standing, lying, lying with head low, left side, right side etc.)
12. How do you feel during and after exercise? Which movements do you prefer? (running, walking, dancing, yoga etc.)
13. Do you tend to run warmer or chilly?

21. Food Cravings/Desires/Aversions

1. How is your appetite and overall digestion? (bloating, reflux, diarrhea, constipation, always hungry...etc.) Please be specific.
2. Which foods or spices do you crave?
3. Which foods do you have an aversion to, or refuse to eat?
4. Would you consider yourself thirsty? Do you prefer cold drinks, hot drinks?

22. Mind/Emotions

Your mind has tremendous influence on your body. In giving proper attention to the whole person, it is necessary to understand your emotional and intellectual nature. Please answer the following *freely, carefully, and completely*. This information will help in formulating a correct homeopathic prescription, which will in turn, help to improve your mental state and overall health

1. Are you anxious or do you worry a lot? If yes, please indicate about what? (work, finances, relationship, illness, family etc.) How do you deal with these worries?

2. Are you fearful of anything such as: animals, snakes, rodents, people, being alone, darkness, death, disease, robbers, ghosts, sudden noises, thunder, the future, the unknown, heights, closed in places, failure, to do new things, speaking in public, etc.? Describe.

3. Would you consider yourself a jealous person and if so what and whom are you jealous of?

4. What makes you impatient?

5. What are the greatest griefs you've had in your life? How did you react?

6. How long do you hold grudges? How much and how often do you seek revenge?

7. What are you most proud of in yourself and your life? What are the greatest joys in your life?

8. How would you describe your self confidence?

9. Is your pride or feelings easily hurt? If yes, by what?

10. Are you ever depressed or brooding? If so, how do you deal with these feelings, do you keep them in or let them out?

11. Do you ever become suicidal? If yes, when, and in what way do you contemplate ending your life? (Please also specify if even then, you are fearful of dying.)

12. Do you weep easily? If yes, what makes you weep and how do you feel afterwards?

13. How do you feel if someone offers sympathy or consolation?

14. How do you feel when you are criticized?

15. What situations are you most sensitive to (where strong feelings are most likely to be aroused)? Describe the situation and the feelings. (ie: injustice, anger, betrayal etc.)

16. When are you most happy?
17. Are you easily irritated? What situations irritate you?
18. What makes you angry? And, how do you express your anger?
19. What bodily symptoms do you develop when you are angry (trembling, sweating etc.)?
20. Do you have any unwanted thoughts at any time? If yes, describe these unwanted thoughts.
21. Do you have any imaginary sensations or fears?
22. How is your memory (if poor specify if it is with names, faces, places, information that is read, etc.)?
23. Do you like company or do you prefer to remain alone?
24. How do you feel in crowds?
25. Would you describe yourself as orderly, fastidious, how does the orliness, or cleanliness of your surrounding affect you?
26. What would you like to change most about yourself (if anything).
27. Do you ever feel despair and if so in which situations?
28. Are you worried or unhappy about any personal, domestic, economic, social or other present situation in your life? If yes, please describe.
29. How would other people view you?

23. Sleep/Dreams

1. How much sleep do you require? How much sleep do you get? If you wake up at night, at what time?
2. Describe your posture in sleep (back, side, abdomen etc.).

3. Are you able to sleep in any position? If not, specify in which position you *can't* sleep.
4. Do you do anything when you sleep? (Snore, Grind teeth, Drool, Perspire, Keep your eyes or mouth open, Walk, Talk, Moan, Weep, Become restless, Wake up with a jerk, Legs jerk)
5. Do you sleep with your window open or closed?
6. How much of yourself do you cover while you sleep?
7. Do you have to uncover any parts?
8. Do you have any recurring dreams or nightmares? If so, please explain in detail their content.

24. Women's Health:

1. Age of first menses? ____ Any difficulties with your period at that time?
2. Age of cessation of menses? ____ Any difficulties associated with menopause?
3. Are your menses regular? ____ If not, describe your menstrual patterns
4. Do you experience PMS? _____ If you do experience PMS, describe the symptoms.
5. Is your sexual energy: Non-existent ___ Low ___ Medium ___ High ___ Very High ___
6. Number of pregnancies? ____ Deliveries? ____ Miscarriages? ___ Abortions? ____
7. Have you every experienced cystic breasts?
8. Do you have any discharge? ___ If yes, please describe the color, odor and consistency.
9. Have you had uterine fibroids?
10. Do you have recurring vaginal infections? Never ___ Rarely ___ Frequently ___
11. Do you experience recurring bladder infections? Never ___ Rarely ___ Frequently ___

25. Men's Health:

1. Do you ever have difficulties getting and maintaining erections? Explain.
2. Do you have difficulties with premature ejaculation while having intercourse ?
3. Is your sexual energy: Non-existent ___ Low ___ Medium ___ High ___ Very high ___
4. Are your erections ever painful ?
5. Do you have any difficulty voiding (urinating) completely?
6. How often do you get up to go the bathroom at night?
7. Have you ever been diagnosed with prostate problems?

26. Spiritual/Religious Background

Recent studies have demonstrated how our faith and spiritual practices affect our health. However, faith, religion and spiritual practices are very personal in nature. You are free to omit any question that you do not wish to answer.

1. What are your religious roots?:

Agnostic ___ Buddhist ___ Christian ___ (please circle: Orthodox /Protestant/Roman Catholic)
Christian Science ___ Jehovah's Witness ___ Jewish ___ Hindu ___ Islam ___ Mormon ___
New Age ___ Other _____

2. Are you an active participant in your religious faith?

3. Do you participate in any other spiritual practices? (describe)

4. What spiritual disciplines do you practice regularly? Prayer ___ Meditation ___ Journaling ___
Study Group ___ Fasting (for spiritual purposes) ___ Other

5. Do you have any dietary restrictions that you adhere to as a part of your faith?

6. Your present faith/spiritual practices are: Very important ___ Somewhat important ___
Not very important ___ to your everyday life.

7. What has been the most important spiritual influence on your life?

Thank you for taking the time to fill out this questionnaire.