

**ATLANTA CLASSICAL HOMEOPATHY**  
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**Homeopathic Intake Form**

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

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

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Time: \_\_\_\_\_

Day of the week you were born: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Children/ Names/Ages: \_\_\_\_\_

Specific philosophy or religion practiced now? \_\_\_\_\_ As a child? \_\_\_\_\_

Sex: M/F Marital Status: Single /Married / Living with partner/ Separated / Divorced /  
Widowed

Live alone / Live with:  
\_\_\_\_\_

Emergency Contact /Relationship: \_\_\_\_\_

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

Referred by: \_\_\_\_\_

Have you had or are you familiar with homeopathic treatment? Y /N If yes, when and what?

List ALL medications, vitamins, or herbs you are currently taking, how long you taken each substance, and why.

Please list your mental, emotional, and /or physical health problems, from the most to the least significant.

Condition:

When did it begin?

What worsens the condition?

What improves the condition?

Condition:

When did it begin?

What worsens the condition?

What improves the condition?

Condition:

When did it begin?

What worsens the condition?

What improves the condition?

Is there any other information about your health that you would like to add?

What do you think is at the heart of your problems?

What feelings surface, as you identify the heart of your problems?

What goals or longtime dreams for yourself have you not been able to achieve?

What were your fears as a child?

What are your fears now?

What time of day do you experience the lowest energy and vitality?

Are most of your symptoms on the right or left side of your body?

Is there anything in the environment that is disturbing to you? (For example, some people have an aversion to the wind.)

How do you feel about thunderstorms?

How much do you like to dance, on a scale of 0 – 10?

How do you feel about having a bowel movement, when there is company in the house or when you are away from home?

Do you have a strong desire to travel?

List anything that is especially stressful to you now, such as relationships, job, school, finances, children, etc.

Please list in chronological order any major illnesses, accidents, grief, and emotional or physical traumas you have experienced. Give your approximate age at the time of the event. Please use the back of this page, if necessary.

Age:

Event:

Please state the health of your mother during her pregnancy with you.

Was your birth normal?

Were you breastfed? How long?

Give any information you have about your health during your infancy?

How has your general state of health been? Excellent/ Good /Fair/ Poor

Do you wake up refreshed in the morning?

What is your energy level on a scale of 1 to 10? (Increasing scale)

Mark the childhood illnesses you have had and give you approximate age at the time:

Childhood Illness:	Age:
Polio	
Asthma	
Chicken Pox	
Rubella	
Measles	
Whooping Cough	
Scarlet Fever	
Mumps	
Other:	

Mark any immunizations you have received and give your approximate age at the time.

Immunization:	Age:
Smallpox	
DPT	
Typhoid	
Flu	
MMR	
Polio	
TB	
Hepatitis B	
Other:	

Did you experience any reaction to any immunization? Y / N If yes, explain.

Mark any tests that you have had. Indicate your age at the time.

Test:	Age:
Chest X-ray	
Kidney X-ray	
G.I. Series	
Colon X-ray	
Gallbladder	
X-ray	
EKG	
TB test	
Other:	

Underline the following conditions that apply to you now and put an X beside the ones that have applied to you in the past.

- |                    |                 |                |                 |
|--------------------|-----------------|----------------|-----------------|
| Allergies          | Gonorrhea       | Cancer         | Frequent colds  |
| Diabetes           | Syphilis        | Tumors         | Bronchitis      |
| Excessive Drinking | Migraines       | Pneumonia      | Heart condition |
| Drugs Usage        | Chlamydia       | Rheumatism     | Sinusitis       |
| Eczema             | Anemia          | Warts          | Hepatitis       |
| Emphysema          | Arthritis       | Dehydration    | Easy bruising   |
| Liver disease      | Gout            | Herpes         | Obesity         |
| Jaundice           | Mental Problems | AIDS           | Asthma          |
| Tuberculosis       | Head injury     | Hypothyroidism | Easy Bleeding   |
| Kidney Disease     | Hyperthyroidism |                |                 |

### Hospitalizations

Reason for Hospitalizations:

Date:

Mark any of the following that you use and indicate the amount or frequency of usage.

Substance / Item	Amount / Frequency
Cell Phones	
Coffee	
Cigarettes	
Alcohol	
Laxatives	
Cortisone medication	
Aspirin	
Water beds	
Hormone treatment	
Vitamins	
Electric blankets	
Medicinal herbs or teas	
Recreational drugs	
Birth Control pills	
Sedatives or tranquilizers	
Other drugs	
Diet pills	
Diet drinks	
Microwave oven	

Are you allergic to any drugs? Y / N If yes, which ones? What happens?

Are you allergic to any foods or other substances? Y /N If yes, which ones? What happens?

### Family History

For the following family members, please put an X beside the ones who are deceased. Indicate current age or age deceased, and list their ailments.

Family Member	Deceased?	Current Age/ Age Deceased	Ailments
Mother			
Father			
Sister/Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please mark any condition(s) that any of your blood relatives have had.

Allergies	Eczema	Heart attack
Anemia	Skin Disorder	High blood pressure
Arthritis	Glaucoma	Seizure / Epilepsy
Asthma	Gout	Sickle Cell Anemia
AIDS	Hay fever	Stroke
Easy bleeding	Gonorrhea	Thyroid disorder
Easy bruising	Syphilis	Tuberculosis
Cancer	Venereal Disease	Learning Disabilities
Diabetes	Alcoholism	Suicide attempts
Depression	Abuse	Addictions

### Military Service

Did you serve in the Military? Y/N If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

How long did you serve? \_\_\_\_\_

Did you contract any illnesses while serving? Y / N If yes, what?

Did you have any vaccinations during your time in the military? Y / N If yes, which?

## **Dietary and Digestive Information**

What is a typical day's diet?

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

How frequently do you eat?

Who prepares your food?

What foods or other substances (tobacco, alcohol, coffee etc.) do you crave?

If everything were good for you, what would you most desire to eat?

Do any foods aggravate you? Y/ N

If yes, in what way?

How often do you eat restaurant food?

How much water do you drink?

What type of water is it? Tap /Distilled / Filtered / Spring / Well

How often do you have a bowel movement? \_\_\_\_\_

Do you strain during bowel movements? Y / N

Has your appetite changed? Y/ N If yes, has it increased or decreased?

## Symptoms

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Skin

Rough/Dry/Scaly/Bumpy/Itchy/Rashes/Warts/Moles/Cysts  
Light/Dark patches of Skin  
Increased hair growth in unusual places  
Pimples: where?  
Color changes in nails  
Hives  
Loss of hair: where?  
Nails: ridges/pits/spots  
Infections: how often?

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### Blood-Lymph-Immune System

Swollen or painful lymph nodes	Bleeding from unusual places
Wounds that heal slowly	Swollen glands
Difficulty stopping bleeding	Easy bruising
Anemia	

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### Endocrine

Excessive hair growth: where?	Can't stand the heat
Unexplained weight loss or gain?	Chronic Fatigue
Prefer hot weather	Cold hands /feet
Prefer cold weather	Increased / decreased thirst
Weakness	Increased / decreased hunger
Can't stand the cold	Excessive sweating: where?
Night sweats	

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### **Head**

Dizziness  
Double vision  
Severe Headaches  
Migraines

Seizures / Fits  
Fainting spells  
Injury / Blow to the Head

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### **Eyes**

Poor eyesight: near/ farsighted  
Eyes sensitive to light

Frequent Infections  
Injury to the eye

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### **Ears**

Discharge from the ears  
Frequent infections  
Hearing trouble

Injury to the ears  
Ringing or other sounds in the ears  
Pain in the ears

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### **Nose**

Nose bleeds  
Sinus problems  
Loss of smell

Injury to the nose  
Difficulty breathing through the nose

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### **Mouth**

Sore Mouth / Tongue  
Cold sores  
Poor dentition  
Dental fillings? What kind?  
Bridges

Infections  
Loss of teeth  
Speech difficulty  
Crown  
Root canal

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Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### Throat

Infections  
Persistent hoarseness  
Difficulty swallowing

Loss of voice  
Swelling pain

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### Neck

Stiffness: Improved by?  
Worsened by?  
Swelling: Improved by?  
Worsened by?

Injury to the neck

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### Respiratory System

Unexplained fever  
Chest pain with breathing  
Daily cough  
Difficulty breathing at night

Night sweats  
Infections  
Shortness of breath

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### Cardiovascular

Chest pain upon waking  
Ankle swelling  
Shortness of breath  
Heart palpitations  
Skipping heart beat  
Fluttering

Leg vein trouble  
Leg pain when walking  
High blood pressure  
Difficulty climbing stairs  
Rheumatic fever: when?

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Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### **Gastrointestinal**

Color of stools: green / yellow / clay	Stool has foul odor/ shows undigested food
Bad Breath	Bad taste in mouth / body odor (also feet)
Indigestion: fullness, bloating, sourness etc.	Heavy, full feeling after eating
Flatulence	Sleepy during the day
Symptoms aggravated by worry and tension	Loss of appetite
Constipation/ diarrhea	Feel better/ worse in the afternoon
Belching / stomach cramps /colicky sensations	Feel better/ worse in the morning
Injury to the stomach	Weight gain / weight loss
Infection	Overweight

Nervous, shaky feeling, and /or headaches, relieved by eating sweets  
Irritable if late for a meal, miss a meal, or before breakfast  
Sudden, strong craving for sweets or alcohol  
Wake up hungry during the night

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### **Spine and Extremities**

Joint pain /Swelling / Stiffness/ Tingling / Numbness	Burning of soles of feet
Muscle cramps	Spinal pain: where?
Backaches	Arthritis: where?
Unusual redness on palms of hands	Injury: where?

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### **Nervous**

Loss of balance	Involuntary movements
Paralysis	Tremors (shaking, trembling)
Lack of strength	Numbness
Convulsions (seizures, stiffness)	

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### **Mental**

Nervousness	Cannot remember dreams
Restlessness	Trouble sleeping
Excessive worry	Frequent nightmares
Memory problems	Depression
Trouble concentrating	Easily angered
Crying Spells	Fearful
Mood swings	Hear voices
Excessive stress in life	See things others do not
Feelings of worthlessness	Suicidal

Feel better as a result of exercise  
Trouble getting along with people  
Loss of someone dear through death or separation  
Always put others' interests before mine  
Think others want to hurt me  
Don't know how to relieve stress  
Generally, late for appointments  
Frequently procrastinates  
Peculiar sensations: What?  
Obsessive habits or thoughts  
If you have recurring dreams, what are they about?

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### **Genito-urinary System**

Frequent urination	Trouble starting urine
Painful urination	Blood in urine
What color is your urine?	Do you have night urination?

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### **Male Problems**

Prostate problems	Infection: Where
Discharge from penis	Infertility
Difficulty achieving or maintaining an erection	Injury: Where?
Painful erection	Premature ejaculation
Difficulty ejaculating	Testicles: Lumps / Swelling / Pain

Underline the symptoms that apply to you now and put an X beside the ones that have applied to you in the past. Where appropriate, fill in the blanks.

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### **Female Problems**

Discharge from vagina  
Painful sex  
No lubrication when aroused  
Never or seldom have orgasms  
Lumps in breast

Menstrual flow: excessive / absent  
Bleeding or spotting between periods  
Painful period: before/ during/ after  
Pelvic pain  
Infertility

Premenstrual symptoms: Cramping / Water Retention /Breast Tenderness/ Headaches/  
Depression / Irritability / Other?

Menopausal symptoms:  
Y / N If yes, since when? \_\_\_\_\_  
What are your menopausal symptoms?

Infection: Where? When?

### **Additional Questions for Women**

Number of births \_\_\_\_\_  
Number of abortions \_\_\_\_\_

Number of pregnancies \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_

Nursed children? Y / N  
Did you have any complications with the pregnancies? \_\_\_\_\_

If yes, how long? \_\_\_\_\_

How old were you when you started menstruating? \_\_\_\_\_

Do you have any nipple discharge? Y / N

How often do you have your period? \_\_\_\_\_

How long does your period usually last? \_\_\_\_\_

What is the number of tampons or pads used daily? \_\_\_\_\_

What is the date of your last period? \_\_\_\_\_

What type of contraception do you use? \_\_\_\_\_

Have you ever or do you now use any kind of hormone pill? \_\_\_\_\_

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### **Final Remarks**

Is there anything you would like to add?

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## ADDITIONAL INTAKE FORM FOR CHILDREN, SEVEN YEARS AND YOUNGER

Name of the child: \_\_\_\_\_

Names of the parents: \_\_\_\_\_

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

### I. Observation: please circle the descriptions that apply to your child.

- A. Eyes: soft, sharp, fearful, hysterical, delicate, angry, irritable, dissatisfied, painful, other: \_\_\_\_\_
- B. Body: restless, slow, sensitive, clumsy, coordinated, other: \_\_\_\_\_

### II. Behavioral Analysis

- A. Does the child prefer to play alone or with others?
- B. Is the child a follower or a leader?
- C. Does the child play with younger children or with peers?
- D. Is the child imaginative?
- E. Is the child competitive or aggressive?
- F. How does the child react to physical pain?
- G. How does she/he play with animals or toys?
- a) roughly   b) fearfully   c) gently   d) obsessed with a toy or blanket

### **III. Independent vs. Dependent**

- a. Is the child responsible?
- b. How does she/he handle being alone?
- c. What is the child's reaction if she/he does not get what she/he wants?
- d. What is the child's reaction to strangers?

### **IV. Patterns**

- a. What are the child's sleep patterns?
- b. When is the child fed?
- c. When does the child play?

### **V. Mental/Emotional States**

- a. Is the child very sensitive to pain, injury, noise, or touch?
- b. Does the child prefer to be carried?
- c. Is the child better or worse with attention or consolation?
- d. Is the child sensitive to other's pain, to parents' fighting, to weather, to movies, or to sad stories?
- e. Is the child easily startled?
- f. How does she/he get along with siblings?
- g. Has the family moved many times?
- h. Is there any alcoholism, drug use, or tension in the family?
- i. Is there fear of punishment by God?
- j. How is the child punished?
- k. When is the child punished?
- l. Is the child compared to siblings or parents?

**VI. Objective symptoms**

- a. What is the most common facial expression of the child?
- b. Are the pupils dilated?
- c. Does the child's skin look healthy?
- d. Does the child sweat? If yes, what part of the body sweats? Is the odor of the sweat offensive?
- e. Does the child have offensive breath?
- f. What is the child's reaction to light?
- g. Does the child have blood in her/his stool?
- h. What is the color of the stool?
- i. Strength:
  - i. How strong is the child's grip?
  - ii. How is the child's posture?
  - iii. How does the child hold his/her head?

**VII. Sleep:**

Does the child have insomnia due to pain, fear, over-excitement, want of attention, or an overactive mind?