



Integrated Health Solutions

Homeopathy Symptom Survey

Name: _____ **Date of birth:** _____ **Today's Date:** _____

This survey will allow your practitioner to evaluate your whole person more completely in order to provide you with individualized care. All information will be held confidential.

Age: _____ Are you married or single? _____ Do you have children? _____

If yes, how many children? _____ Profession: _____

For a child, please provide information about the rest of the family, and for a young child, details about the pregnancy:

Please describe, in as much detail as possible, your reason for seeking treatment. What are your primary health concerns?

When did your symptoms start? _____

What caused the symptoms initially? Can you suggest any factors that may have contributed to these symptoms?

Does anything make it better or worse? Please list anything that may make it better or worse (e.g., standing, after sleep, heat, cold, pressure, etc.)

If this is a physical complaint, how does it affect you emotionally?

Please describe anything associated with the current symptoms that feels unusual, rare, or peculiar, or include any other information you wish to add.

What medications are you currently taking? _____

Are you receiving any other treatments (chiropractic care, acupuncture, herbs, etc.)?

Please list all homeopathic treatments you've had, including which remedies were used and whether there was a positive or negative reaction:

Please list all relevant medical history, including any significant illnesses, diseases in the past, operations or surgeries, hospital stays, accidents or injuries, any family history of disease, etc.

Please describe any important events in your life. How did you feel about them at the time? How do you feel about them now?

Please list any other complaints. Note when they started, whether anything caused them, and what makes them better or worse. Please indicate the intensity in brackets from either 1 to 3 with 1 being mild and 3 being intense.

Please go over your body from head to toe, looking for any other problems (head, ears, nose, throat, chest, digestive system, urinary system, joints, skin, hands, or feet).

If you are female, please described your menstrual cycle?

Are you generally a hot or cold person? _____ Do you perspire easily? _____

How do you react to weather and temperature (dry, damp, hot, cold)?

Please list any foods that you especially love, dislike, or that causes problems:

Please list any major psychological or emotional concerns, such as fears, anxiety, anger, grief, or things that affect you strongly.

Please describe any recurring or significant dreams:

Please list any problems with thinking, concentration, or memory:

Please describe any recurring or significant dreams:
