

# Homeopathic Questionnaire: Adult

Kimberly Woods, HP • (828) 645-2919 • <http://diymedicinerevolution.com>

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

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

Phone: (day) \_\_\_\_\_ (eve) \_\_\_\_\_

Marital/Relationship Status: \_\_\_\_\_ Date of Birth:

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

PLEASE USE A SEPARATE SHEET TO ANSWER THE FOLLOWING QUESTIONS:

1. What is your chief complaint (CC)?
2. When did this problem begin? What happened in you life around that time? What do you think caused it?
3. What aggravates the CC? (Certain types of foods or weather, movement, light, noise, heat/cold or anything else that you can think of. Please be specific.)
4. At what time of the day or night is CC the worst? Specify an hour if you can.
5. What symptoms can you identify that accompany the CC?

## GENERAL QUESTIONS

6. Questions about the weather and environment: you only need to answer those, which apply to you.
  - a. In which season does the weather bother you the most?
  - b. How do you react to cold, hot, dry, wet or windy weather? Please mention any and all types of weather that affect you, and how.
  - c. How does a change of weather affect you?
  - d. How do you feel in bright sunlight?
  - e. Do you have any special reactions before, during or after a storm? Please specify.
  - f. How do you react to drafts of air? (e.g. open window, having a fan on you) Do you sleep with the window open even when it's cold out?
  - g. How do you react to sudden changes in temperature (e.g. going from a cold environment to a hot room or vice versa)?
  - h. What about warmth in general, warmth of the bed, of the room, of the heater or stove?

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- i. How do you feel at the seashore, or on high mountains?

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7. What position do you dislike the most: sitting, standing, lying?
8. Do you perspire a great deal? If so, when and where on the body? (Feet, head, armpits, etc.)
9. What time of day tends to be a down time for you?

## MENTAL/EMOTIONAL

10. What do you worry about? How do you deal with worries?
11. Do you tend to be neater and more fastidious than those around you, or more casual?
12. Do you cry easily? In what situations?
13. When you are upset, do you tend to tell a lot of people or keep it to yourself?
14. On what occasions do you feel despair?
15. In what circumstances do you feel jealous?
16. When and on what occasions do you feel frightened or anxious? Any fears (darkness, being alone, in crowds, altitude, flying, elevators, etc.)?
17. What are the greatest grief's that you have gone through in your life? How did you react?
18. What are the greatest joys you have had in your life?
19. In what situations do you feel the blues, depressed, sad, pessimistic?
20. What bothers you most in other people? How, if at all, do you express it?
21. Do you have a lack of self-confidence or a poor sense of self worth?
22. Do you have any recurring dreams? What is the theme?
23. What would you need to feel happy?
24. What do you do for work? Ideally, what would you like to do?
25. If you had an unexpected week's vacation from work and \$1,000, what would you do?

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26. How do other people view you?

27. What would you like to change most about yourself?

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## FOOD

28. How do you feel before, during and after meals? How do you feel if you go without a meal?
29. What would you most like to eat (if you did not have to consider calories, fat, anything you've read about the right way to eat)?
30. What foods do you dislike and refuse to eat? What foods do you react badly to, and in what way?
31. How much do you drink in a day? Include sodas, juice, coffee, tea, milk and alcoholic beverages as well as water. How thirsty do you tend to get?

## SLEEP

32. What hours do you sleep? Do you tend to wake up at a particular time? Why? What makes you restless or sleepy?
33. Do you do anything during sleep? (Speak, laugh, shriek, toss about, grind your teeth, snore)
34. How do you feel in the morning?

## WOMEN

35. Number of pregnancies, number of children, number of miscarriages, number of abortions?
36. At what age did your menses begin? If you have gone through menopause, at what age?
37. How frequently do the (or did they) come?
38. What about their duration, abundance, color, time of day when flow is greatest; any odor or clots?
39. How do you (did you) feel before, during and after menses?

## HEALTH HISTORY

40. What medications are you taking at present?
41. How frequently do you get colds or flu?

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42. Have you had any childhood illness twice, or in very severe form, or after puberty?

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43. Have you had vaccinations since the standard childhood ones? Have you ever had an adverse or unusual reaction to a vaccination?
44. Have you had any surgery? What and when?
45. Have you had at any time (mention year): What therapy was given?
- Warts: where? When? How treated?
  - Cysts: where? When? How treated?
  - Polyps: where? When? How treated?
  - Tumors: where? When? How treated?
46. Do you tend to have any discharges (nasal, vaginal, etc.)? Please describe color, consistency.
47. Sensitivity:
- Do you tend to need a smaller dose of medications than most other people?
  - Do you tend to need less anesthesia than others, or have a hard time coming out of it?
  - Do you tend to react to vitamins and herbs and/or need hypoallergenic vitamins?
  - Are you sensitive to paint fumes, exhaust, dry cleaning fluid, fragrances, etc.?
48. Family History: Mention diseases, causes and ages of deaths of father, mother, sisters, brothers and grandparents on both sides.
49. Construct a time line: Mention from birth on to the present day, all important events (emotional and physical traumas, heartbreaks, divorces, work-related events, diseases or traumas you mother had while pregnant with you, family stress, death in the family or of friends, disappointments, etc.) Mention the symptoms experienced at those moments or which you can date to those traumas. Please try to write at least one page outlining major events of your life.
50. What else would you like to tell me about yourself or your condition?