Homeopathy For Families

New Patient Intake Form

Mary Nuñez BSN D.Hom

Today's Date_____Date of Birth_____

Name_____

Home Address_____

City_____State_____Zip_____

Home phone_____Cell phone_____

Email address_____

Referred by_____

Primary care Physician_____

Previous Homeopathic treatment_____

Gender_____ M_____ F Marital Status_____Height_____Weight_____

Occupation_____

What makes you seek homeopathic treatment at this time ?_____

_____

_____

_____

Members in your household

Name	relationship	age

Medications that you take and any medicinal herbs,vitamins,supplements,homeopathic remedies:

Medication name	when started	dose/frequency	for?

Allergies? (to medications,environmental,foods,etc.)_____

What experiences in your life have affected you deeply?_____

What are your hobbies and things in life that you enjoy?_____

What are your fears and anxieties, past or present? (situations, animals, people, events, etc.)_____

Please describe an ideal day in terms of weather, temperature, and environment._____

What are your favorite foods and flavors that you crave to eat?_____

What foods to you dislike or have an aversion to?_____

What is your normal body temp? (do you run hot, warm or cold?)_____

What position do you sleep in and do you sleep well through the night?_____

How is your energy? What time(s) of day is it best?_____

History of physical problems in past (mark with X) **and current (**please circle)

___Headache
___Dizzy spells

___Loss of balance
___Black outs/fainting

___Back pains
___Neck lumps/swelling

___Wear glasses
___Blurry vision
___Eyesight worsening
___See double
___Eye pains/itching

___Head colds
___Nose bleeds
___Sore Throat
___Difficulty swallowing
___Hoarse Throat
___Wheezing/gasping
___Frequent coughing
___Cough up phlegm
___Chest colds

___Runny nose
___Sneezing spells
___Sinus Problems
___Recurrent colds/flus

___Indigestion
___Frequent belching

___Nausea/vomiting
___Abdominal Pain
___Constipation
___Flatulence

___Loose stools
___Black stools
___Gray or whitish stools
___Pains in rectum
___Itchy rectum

___Frequent urination
___Painful urination

___Aching muscles/joints
___Swollen joints
___Back or shoulder pains
___Weakness in arms and legs
___Pain in feet
___Trembling
___Numbness
___Leg cramps

___Skin rash
___Scalp problems
___Itchy burning skin
___Easily bruised
___Warts

Men Only
___Burning

___Discharge
___Painful/swollen testicles
___Impotence
___Difficulty maintaining erection
___Premature ejaculation
___Injury

Women Only
___Missed periods
___Menstrual issues
___Bleeding between periods
___Pain before, during, after period (circle)
___Bearing down feeling
___Discharge from vagina
___Genital irritation
___Painful intercourse
___Swelling of breasts

# of pregnancies ____
# of births ____
# of miscarriages ____
# of abortions ____
premature births ____
of cesareans ____

Comments or special problems:_____
_____
_____
_____
_____

Do you drink coffee or tea? How much?_____

Do you smoke or have a history of smoking?How much?_____

Do you drink alcohol, how much?_____ **recreational drugs?**_____

What do you do to relax?_____

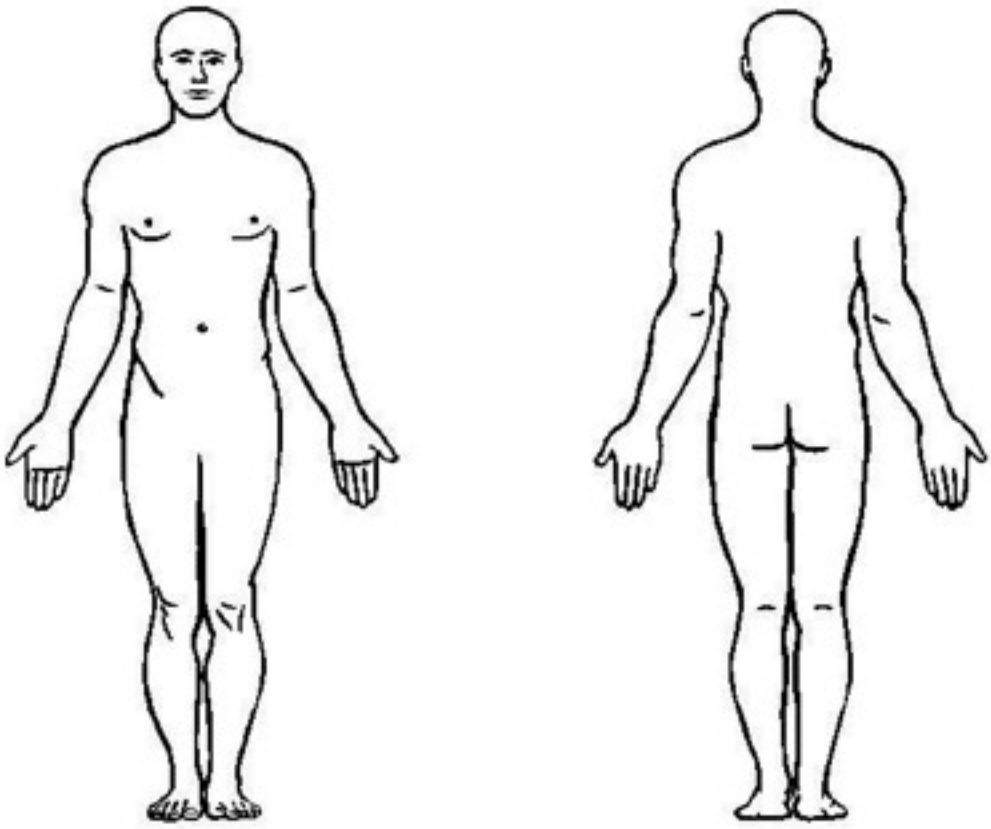
Do you like your job?_____**How many hours/week do you work?**_____

Do you get regular exercise and what kind?_____

Are you spiritual?_____**Religious?**_____

Did you receive all childhood vaccinations? Any problems?_____

Please mark the areas where you feel pain with an X and include a description word or two of the type of pain or sensation.



Family Health History: *Check if applies to a blood family member and indicate their relationship to you.*

__Alcoholism	__Diabetes:	__Mental Illness:
__Allergies:	__Drug Addiction:	__Narcolepsy:
__Anemia:	__Eczema:	__Rheumatism:
__Arthritis/Gout:	__GI Ulcer:	__Stroke:
__Asthma:	__Glaucoma:	__Suicide:
__Auto-immune disorder:	__Hay Fever:	__Tuberculosis:
__Cancer:	__Heart Disease:	__Bleeding problems
__Depression:	__Thyroid disorder:	__Venereal disease
__Weight problems	__High blood pressure	__Abnormal periods

__Other:

Circle the following below that you strongly associate with yourself.

Hurried, impatient	Messy	Restlessness	Lazy	Extravagant
Shy/timid	Anger	Sympathetic	Stubborn	Reckless
Dislike company	Stingy	Thrifty	Slow	Desire for company
Fastidious	Calm	Always busy	Outgoing	Mildness
Guilty	Yielding	Coward	Worried	Religious
Lonely	Sexual	Weepy	Forgetful	Optimistic
Sadness	Bossy	Disorganized	Grief	Sentimental
Assertive	Easily Hurt	Loving	Secretive	Affectionate
Carefree	Jealous	Nightmares	Fearful	Procrastinate

Homeopathy is considered to be an alternative/preventative system of health care and is not intended to be a substitute for allopathic or traditional medicine. The therapy and information offered should not be construed by you, the client, or any family, friends or caregivers to be a medical diagnosis of any disease or injury. You should consult with your physician for any serious medical condition. I understand that Mary Nunez is not a medical doctor, but a homeopath. I further confirm that all the above information is correct to the best of my knowledge.

Signature:_____ Date:_____

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