TWO LEGS AND FOUR HOMOEOPATHIC HEALTH
131 Loton Road, Millendon, Western Australia (08) 9296 0152

ADULT MEDICAL BACKGROUND FORM

Please fill out what you can and email it back to me before the consultation. This is not compulsory, but it does save time.

All details of this questionnaire are strictly confidential.

Date:

Name:

Date of birth:

Place of birth:

If not born locally, how long have you been here:

Address:

Daytime phone, if in Australia:

Mobile, if in Australia:

e-mail address:

Where/who did you hear about me:

What is your occupation/career choice?

Current Health Concerns

What is your main complaint, the complaint that bothers you the most, which you want fixed as a priority?

When did it first start?

List any other complaints?

When did they start?

Please list any medication you are taking on a regular basis, including health supplements:

Environment

Please detail any environmental factors which affect you. Listed are some examples, but you may have more.

Seasons -
Heat/Cold -
Humidity -

Dry weather -
Change in weather -
Wind -
Thunderstorms -
Phases of the moon -
Stuffy, closed or warm room -
Fresh air -
Sea -
Sun -
Being in the bush -
Mountainous regions -
Smoke -

Health History

Under the headings below, please list any past illnesses, injuries, major traumas that affected you strongly, including the approximate age. Please include any information that seems interesting or unusual. Don't leave out anything important.
Please detail the medical treatment received as well as any adverse reactions to the treatment.

Illnesses, including those in childhood

Injuries, Traumas - Physical or Psychological

Your Mother's Pregnancy With You and Your Birth

Please detail anything you know about this including any medical interventions. How was it for your mother.

Vaccine History

Please give details of past vaccinations with your approximate age or the dates, including any adverse reactions. The common ones are listed below, to help you:

DTP -
Polio -
Whooping cough/Pertussis -
MMR -
Chicken pox -
HIB -
Hep A or B -
PCV -
BCG -
Malaria -
Smallpox -
Typhoid -
Yellow fever -
Cholera -
Gamma globulin -
Flu -
Tetanus -
Gardasil -
Any other vaccinations -

Surgery, Operations

Please list any surgery you have had, with the approximate dates:

Medical tests

Please detail the radiation tests you have had, such as X-rays, cat scans, MRI scans, etc, including dental:

Allergies

Do you have any allergies - from food, drugs, the environment, etc.
Details when they started, the severity on a scale of 1 to 10 and if you still have them

For Women

At what age did your periods start -
How many days do/did they last -
How frequent are/were they -
Describe the flow over the duration -
Describe the consistency -
Describe the colour changes over the duration -
Do/did they have clots -
Is/was there any pain -
If so where and when -
Do/did you suffer from moodiness or irritability at this time -

Are you or were you on the oral contraceptive pill or the depo provera contraceptive injection -
How long for -
Do/did you suffer any side effects -
Do/did you have any discharges during the month -
Do/did you notice ovulation -

Are you having or have you had trouble with the menopause -
If so, what -

Pregnancy, Birth, Children

Any history of miscarriage? Please details.

Any history of abortion -

Children

Please copy and paste if you have more than one child.

Conception (eg took 6 months, had IVF, etc) -
How was the pregnancy (eg morning sickness for 1st trimester, shock at 6 months, etc) -
How long was the labour -
What sort of birth did you have -
Could you feed your baby -
How long for -
Did you suffer post natal depression -

Sexuality

Are you sexually active -
Are you in a committed relationship -
What protection do you use (against pregnancy or disease) -
Do you have any sexual discomfort or dysfunction -
Please detail any sexual preferences or habits -
Have you ever had or been treated for a sexually transmitted disease -

Have you ever been the victim of rape or incest? Please give details -

Family History

Family history often contains very important links to where your problem lies, so please give as much detail here as you can:

If you are adopted, it's the biological family history I would like.

Mother: year of birth:
Occupation:
Specific health problems in her life:
If died, what her age and the cause was:

Father: year of birth:
Occupation:
Specific health problems in his life:
If died, what his age and the cause was:

Sibling: year of birth:
Occupation:
Specific health problems in her/his life:
If died, what the age and cause were:

Sibling: year of birth:
Occupation:
Specific health problems in his/her life:
If died, what the age and cause were:

Please copy and paste if you have more than two siblings.

Maternal grandmother:
Specific health problems in her life:
If died, what her age and the cause was:

Maternal grandfather:
Specific health problems in his life:
If died, what his age and the cause was:

Please detail any major diseases on your mother's side of the family

Paternal grandmother:
Specific health problems in her life:
If died, what her age and the cause was:

Paternal grandfather:
Specific health problems in his life:

If died, what his age and the cause was:

Please detail any major diseases on your father’s side of the family.

Please detail any major diseases in aunts, uncles, cousins.

Growing Up

What were you like as a child -

How were your relationships with your parents, siblings, extended family, friends, at school -

Activities, Hobbies

Please list those activities which you most enjoy or have problems with. Please give details. Below is a list, but you may have more.

Standing/walking/running -
Sitting -
Lying down -
Looking up or down -
Climbing or descending stairs -
Reading -
Physical exertion -
Mental exertion -

Recreational Drug/Tobacco/Alcohol Use

Please detail any past or present use. Drug use that your homeopath doesn't know about can be an impediment to correct treatment.

General

Are you affected by any of the following:

Bright lights -
Strong smells -
Sudden noise -
Touch -
Pressure -
Tight clothing -
Being alone -
Being in a crowd -
Being in the dark -
Before an exam or important engagement -
Speaking in public -
Surprises -
Sympathy/Consolation -
Confrontation -
Criticism -

Sleep

Do you have trouble falling asleep?

How well do you sleep?
Do you get insomnia?
Do you remember your dreams?
How do you feel on waking or rising?
Do you snore or suffer from apnoea?
Do you suffer with jerks or twitches during your sleep?
Do you talk in your sleep?
Do you walk in your sleep?
Do you nap?
How do you feel after a nap?

Digestion

Please detail any problems you have with any area of the digestive tract, from the mouth to the anus.

How is your appetite?
Do you have any cravings or aversions?
Are there any flavours which you particular like?
How are you after eating?
How are you after you fast?
Do you prefer hot or cold meals?
How thirsty are you naturally?
How much would you drinks naturally in a day?
Do you prefer hot or cold drinks?

Do you experience gas or bloating?

How often do you have a bowel movement?
What is the stool like?
Do you have to strain?

Please give me details of your typical diet.
Breakfast -
Lunch -
Tea/Dinner -
Snacks -
Drinks -

Urination

Do you have any urinary tract problems?
Is there a strong smell?
Is there any pain?
Is there any difficulty with the flow?
Is there any involuntary urination?

Perspiration

Do you perspire much?
On what parts of the body do you perspire the most?
Does the sweat stain or stiffen the clothing?
Does the sweat have an unusual or strong odour?

Parts of the Body

Please take a few moments to run through any areas that you may not have mentioned already. If you have already detailed them in another area, just put 'as above':

Headaches -
Vertigo/giddiness -
Fainting -
Skin/scalp -
Eyes/visio -
Nose/sense of smell -
Mouth/sense of taste -
What is the appearance of your tongue -
What are your teeth like -
Do you have many cavities or dental restorations -
What sort -
Gums -
Lips -
Throat -
Back -
Limbs -
Joints -
Trembling/weakness -
Paralysis -
Skin - eruptions, warts, moles, itch, numbness, bruising, etc -
Healing of injuries/wounds -
Easy bruising -
Finger and toe nails -

Religion/Spiritual

Please describe what is important to you.

Homeopathy

Please indicate if you have had a consultation with a homeopath before and if so, what remedies were prescribed.

Please indicate any homeopathic remedies you have taken without a consultation.

What are your expectations from your homoeopathic treatment with me?

Comments

CONGRATULATIONS in completing this marathon questionnaire! This is a significant step in your journey to wellness.

Re-scheduling or Cancellations

Homeopathic consultations take time. My appointments are lengthy to discover the core reason for your ill health. So cancellations or failure to arrive for an appointment makes a big impact on my day.

Inevitably there are times where you need to cancel or re-schedule your appointment. Wherever it is possible, I do appreciate you giving me as much notice as possible, at least 24 hours is preferred. Often, people ring me early in the day for an appointment and it is frustrating for us both when there is apparently no free slot, which ultimately becomes available.

Those who fail to come to a prearranged appointment or don’t give me 24 hour advance notice may be charged for the full consultation.

I appreciate your consideration.