Patient Long Distance Intake Form

Fill out all details where there is a problem or there has been a history of a problem.

Date

Name

Date of birth

Age

Sex

Person filling out form – Name and relationship to patient (same/Mother/Father/guardian/friend/career, etc)

Address (including postal code)

Phone number (include international prefix where applicable) –
Phone Home –
Phone Mobile

Email contact

The Homeopathic consultation requires the following aspects of the patient's health to be covered

- Presenting complaint
- Factors that modify that complaint
- Causative factors
- Other complaints whether associated or not
- History of complaints
- Information regarding sleep, appetite, food likes, dislikes and aggravations, perspiration, reaction to weather/season/times, growth patterns, milestones etc
- Character of patient – especially behaviour when under stress or in a negative mood
- Family history
- Life patterns – a brief biography of significant moments in the patient's life

Please answer all questions as fully as possible – even minor characteristics or symptoms can be significant to the choice of remedy. Please keep conventional descriptions to a MINIMUM – it is more important for the Homeopath to know what the patient experiences and how local factors and stress impact on the patient and their complaint. Where a diagnosis or pathology test shows abnormal levels – ie blood, urine, bones, minerals, blood pressure, immune function etc – these should be included

MAIN COMPLAINT

General description of complaint

Onset – date and corresponding factors including any stress at the same time as the complaint commenced or anywhere up to two years earlier than the first sign of the complaint

How the problem presents on a day to day basis

What modifies* the complaint

* = factors that may change the presentation of the complaint – either making it feel worse or feel better (even if for a short time) – examples include food, drink, weather, time, indoors/outdoors, temperature, heat/cold – applications or weather, rain, wind, storms, pressure, touch, movement, sitting, lying (side?), vomiting, sweating, fasting, passing stool, urinating, periods, (before, during, after), time of year, moon phases, sleep (during, after, better for, worse for) waking, exercise, exertion, emotional interaction (weeping, company, being alone, mood changes etc) – **anything** that is noticeable and has been seen as a repeating pattern – *it does not include drugs*

OTHER COMPLAINTS

Description as for main complaint with all information about modifying factors

CURRENT TREATMENT
Name any drugs currently taken (prescription or recreational) and other treatments tried for this complaint – *brief description only*

PHYSICAL OVERVIEW – please answer if any of the following problems exist – give some information about the problem especially modifying factors as above

If the physical problem has ceased please include when it occurred and what made it improve – eg change of diet, change of habits, change of living arrangement, just went, drugs, operation etc

Note – all discharges to be described with their colour and texture – eg clear, yellow, green, bloody, thick, thin, runny, gluey

- Hair – falling out, very dry, very oily, rapid change of colour etc
- Scalp – eruptions, itch etc
- Headaches – patterns and modifying factors
- Eyes – allergies, watery, itching, sties, inflammation, discharges
- Vision – spots, colours, flashes, short/long sighted etc
- Ears – inflammation, discharges, pain, eruptions
- Hearing – loss of, noises (include what the noise sounds like)
- Nose – obstructed, running, discharge, side, growths, blood noses etc

· Mouth – ulcers, cold sores, eruptions, salivation, dryness, taste (sweet, sour, salty, putrid, metallic etc)

· Tongue – unusual colour, cracks, marks

· Teeth – excessive decay, breaking/crumbling, abscesses, discoloration, pain

· Braces – what was wrong with teeth before braces – crooked, overbite, front two protruding, gaps etc (This is important for the facial analysis – if you have a photo of the teeth before the braces please include)

· Throat – sore, inflammation, tonsillitis, itchy, dry, discharge etc

· Larynx – loss of voice

· Speech – stuttering, loud voice, quiet voice, can't remember words, switches words or letters etc

· Breathing – difficult, ascending, descending, on exertion, asthmatic – type etc

· Lungs – inflammation, bronchitis, pneumonia, pleurisy, congestion, coughing etc

· Stomach – pains, relationship to eating/drinking etc

· Digestion – heartburn, pain, reflux, bloating, distension, flatulence, burping

Appetite – food cravings, food dislikes, food that makes you sick – consider the following groups – please tick the box with an x for each category of food and your response to it

Food group	**Crave**	**Like**	**Indifferent**	**Hate taste**	**Makes me sick or allergic to**
Sweet					
Chocolate					
Salty					
Sour					
Bitter					
Fruit					
Vegetable					
Salad					
Meat – steak					
Meat – chicken					
Meat - pork					
Fish					
Eggs					
Cheese					
Yoghurt					
Butter					
Cream					
Oily/fatty/fried					
Bread					
Cakes/pastry					
Spicy					
Herbs					
Hot food					
Cold food					

Drinks	Crave	Like	Indifferent	Hates taste	Makes me sick or allergic to
Coffee					
Tea					
Water					
Fruit juice					
Iced drinks					
Soft drinks					
Milk					
Wine					
Beer					
Spirits					

Any other food interactions that you feel are important – please add here

· Bowels – constipation, diarrhoea, loose stools, colour, shape, odour (where distinctive), blood, undigested, pain, hemorrhoids, frequency, urgency
· Urination – pain, frequency, profuse, scanty, blood
· Periods – age of onset, current or history of - pain – where and description, irregular, heavy, clots, associated problems, pmt (how does this exhibit), better or worse for flow of blood, colour of blood
· Female – libido issues, discharge, warts, cysts, fibroids
· Pregnancy – how many, problems, sterility, abortions, miscarriages – time etc
· Male – libido issues, prostate
· Limbs – pain, cramps, joint problems, numbness, tingling
· Back – pain, sciatica, numbness, tingling
· Hands/feet – cold, hot, sweat, odour
· Skin – dry, oily, eruptions (where), warts, moles, cracks
· Nails – unusual colour, thickness, breaking etc

SLEEP
General description of sleep – including difficulty in getting to sleep, frequent waking, times of waking if there is a pattern, favorite sleep position, hot/cold in bed, sweating, restless, waking unrefreshed, talking in sleep etc

DREAMS
Describe (briefly) the types of dreams you have
Vivid, happy, frightening, nightmares, repeating dreams, repeating themes, a dream when young that still remains as a strong memory

RELATIONSHIP WITH WEATHER/SEASONS
Love/hate
Winter, summer, autumn, spring, hot, cold, windy, rainy, thunder/lightening, direct sun, dry, humid

BODY THERMALS

Chilly, hot, changeable

PERSPIRATION
Never, slight, profuse, hot, cold, when, where

FEARS
Animals – snakes, spiders, dogs etc, heights, strangers, robbers, death, closed spaces, exams, public speaking, driving, ***anything no matter how unusual***
Give a description of how intense the fear is and what happens to you

STRESS
How do you behave when under stress? What are your less attractive behaviors'? What complaint do others have about you?

PASSIONS
What are you most passionate about? Brief description of you and your passion.

LIFE PATTERNS
Describe your life in terms of which events/situations were the *most traumatic, stressful or made a definite impression upon you*. Put them in chronological order from childhood to now

FAMILY HISTORY
Include main illness or weakness – if currently alive or illness at death and age of death

- Mother
- Father
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather

CHILDREN ONLY
Parent please give the following information

- Conception details – any stressful events at that time
- Pregnancy
- Labor – anything unusual
- Infancy – feeding, sleeping, illnesses (not already mentioned in physical overview), reactions to vaccines
- Development – sitting, crawling, walking, talking, teething – normal, late or early – describe in detail if out of normal range

CHILDREN – CHARACTER
How does your child behave when stressed – fights, loud, quiet, shy, timid, hides, hits, throws, jealousy, remorse etc

Interaction with friends, family (especially siblings) and at school
Passions
Unusual or distinguishing behaviors

PREVIOUS REMEDIES GIVEN

Please mention names of previous remedies given (with potency where known) and which ones had a POSITIVE result.

DECLARATION & CONSENT:

I, _____, hereby consent to treatment by Salvatore Messina Hom., and understand and acknowledge that I have the option of seeking/continuing conventional medical treatments and services if I choose to do so.

Notification of any cancellations are required 24 hours in advance, otherwise full fee of missed appointment applies. I agree to pay the fee of each visit in full at the end of each visit.

Signature: _____
Date:_____

Please email forms back to Salvatore@health-source.ca Tel: 647-955-0653