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Homeopathic Questionnaire

DATE: ____/____/_____

Please fill out the Homeopathic Questionnaire completely.
This will help me find the most individualized remedy for you.

PATIENT'S FULL NAME:	
DATE OF BIRTH:	

Do you tend to be more bothered by?: ✓	A room that is too warm	A room that is too cold			
Which season bothers you the most?: ✓	Spring	Summer	Fall	Winter	
How long can you sit in the direct sunlight before it bothers you or causes symptoms (without a hat or sunglasses)?: ✓	0-20 minutes	20-60 minutes	1-3 hours	+3 hours	
Which environment do you find most comfortable?: ✓	Mountains	Ocean side	Humid weather	Dry weather	
Which bothers you the most?: ✓	Warm rooms	Stuffy rooms	Cold drafts	Loud noise	Strong odors	Bright lights
What is the best time of day for you?:					
What is the worst time of day for you?:					
How sensitive to tight clothing are you and where are you the most sensitive?:					

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What is your sleep position?: ✓	Left side	Right side	Abdomen	Back
Do you wake in the night? If so, what time?:				
Do you sleep…?: ✓	Covered	Fully covered including head	Uncovered	Feet sticking out of the covers
How severely do you perspire and where do you perspire the most?:				
What taste do you crave the most?: ✓	Sweet	Salty	Spicy	Bitter	Smoked
If health were not an issue, what foods would you eat on a regular basis or that you crave?:				
What foods do you dislike or are difficult to digest?:				
How much do you drink a day?: ✓	Almost never	Several x/day	Several x/hour	Every few minutes
What temperature water do you prefer?: ✓	Hot/warm	Room temperature	Cool	Ice cold
How clean and organized are you?: ✓	Not at all	Somewhat	Very	
How jealous/envious are you?: ✓	Not at all	Somewhat	Very	
How impatient are you?: ✓	Not at all	Somewhat	Very	

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How irritable/angry do you tend to be?: ✓	Not at all	Somewhat	Very	
How suspicious are you?: ✓	Not at all	Somewhat	Very	
How often do you cry?: ✓	Never	Only when appropriate	Easily	Very easily
How sensitive to sad stories or the news are you?: ✓	Not at all	Somewhat	Very	
How sensitive to rudeness/injustice are you?: ✓	Not at all	Somewhat	Very	
How confident are you?: ✓	Not at all	Somewhat	Very	
Are you nervous about confrontations/public speaking?: ✓	No	Slightly	Yes	Very much so
How critical/hard on yourself are you?: ✓	Not at all	Somewhat	Very	
How critical/hard on others are you?: ✓	Not at all	Somewhat	Very	
How often do you have the urge to throw, hit or slam something, whether you act on this urge or not?: ✓	Never	Rarely	Weekly	Daily

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How often do you dwell on the past?: ✓	Never	Rarely	Weekly	Daily
How sensitive are you to cruel stories/watching the news?: ✓	Not at all	Somewhat	Very	
What population are you most sensitive to hearing cruelties about?: ✓	Children	Adults	Elderly	Animals
Please list any fears you may be having, including any of the following: darkness, thunderstorms, robbers, heights, falling, fainting, small places, something bad happening, death, contagious disease/germs, ghosts, evil, failure, poverty, insanity, fire, insects, dogs, snakes, knives, public speaking:				
How easily are you frightened or startled?: ✓	Not easily	Somewhat easily	Very easily	
How sensitive to criticism are you?: ✓	Not at all	Somewhat	Very	
How much do you like to travel?: ✓	Not at all	Somewhat	Very	
How forgetful are you and what are you most forgetful of?:				

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When you are at your worst, what makes you feel better?:				
When you are feeling the most sad, do you ten to…: ✓	Isolate	Seek distraction	Be around others	Seek consolation
How often do you have the desire for sex/masturbation?: ✓	Never/rarely	<1 x/month	Monthly	2-4 x/month
	2-4 x/week	Daily	Multiple x/day	

Please list any additional comments that you would like your Physician to know in the section below:

I, _____, hereby agree that all of the following is true to the best of my knowledge.

PATIENT'S/GUARDIAN'S SIGNATURE:	