Kailo Homeopathy

Box 10 Site 22 RR2 Strathmore, AB T1P 1K5

Phone: 403.837.7191 Email: kailohomeopathy@gmail.com

Full Name:_____ Birth Date: (DD/MM/YY)____/____/_____

Address:_____ Postal Code:_____

Phone (res)(___)_____Phone (wk)_(___)_____ Phone (cell) (____)_____

Email_____

How do you prefer to be contacted? _____

Employer_____ Occupation_____

Age_____ Height_____ Weight_____

Marital Status_____ Name of Spouse_____

Name of Physician_____

_____

Main Complaints and onset of each complaint:

1, _____

2, _____

3, _____

4, _____

5, _____

_____

Past History (Previous diseases and their treatment)

_____

_____

_____

_____

_____

_____

Family History (Give in detail if any of your blood-relatives i.e. parents, grandparents, siblings, aunts and uncles are suffering or have suffered from the following)

ALLERGIES:

Eczema _____

Hay fever _____

Sinusitis, Cold _____

Allergic bronchitis _____

Asthma _____

Urticaria (Hives)_____

ARTHRITIS:

Gout _____

Osteo-arthritis _____

Rheumatoid arthritis _____

CANCER / MALIGNANCY:

_____

_____

DIABETES MELLITUS:

_____

_____

Hypertension _____

Coronary Artery Disease, Angina, ect _____

_____

Tuberculosis _____

Gonorrhoea / Syphilis or STI _____

_____

Psychiatric & Mental Disorders _____

_____

Schizophrenia _____

Anxiety Neurosis / Depression _____

Any other sickness not mentioned above? _____

_____

_____

PERSONAL HISTORY

APPETITE

Are you a vegetarian _____ Do you eat eggs _____

Cravings & Aversions in Food

Please indicate craving levels by intensity symbols + or ++ or +++ show increasing desire. – or -- or --- show increasing aversion for an item.

Sweets _____ Salty food _____ Do you add Extra Salt _____

Sour things / pickles _____ Seasoned and spicy _____

Milk _____ Fried and fats _____ Any other cravings? _____

_____

DIGESTION

Any complaints after eating? (i.e. fullness of abdomen, gas, diarrhoea, feeling bloated, full or heavy feeling after eating)

_____

Can you remain hungry for hours on end, even after eating food? _____

Do you get irritable with hunger? _____

Does any item of food causes any discomfort? (i.e. heartburn, headache, etc) _____

_____

_____

THIRST

How thirsty are you? (Please circle) never / sometimes / often

How much water do you take at a time? (i.e. sips, gulps, etc) _____

How many times a day are you drinking water? _____

Your preference in drinks

Would you prefer cold, chilled water even in the winter? _____

Would you like your cup of tea or coffee piping hot or just reasonably warm? _____

Any aversion to any drinks? _____

_____

GENERALITIES

State how you are affected by or how you react to the following:

1, How do you react to cold in general, cold air, drafts, cold winds etc? _____

_____

2, Do you like to cover your head (or wear a cap) when you go out in the cold or when exposed to drafts of cold air?

_____

3, How do you react to warmth in general, warmth of bed, warmth of the room, external warmth like a hot compress, etc?

_____

_____

4, What types of weather makes you feel worse – dry, cold wet, rain, cloudy etc? _____

_____

5, How do thunderstorms make you feel? _____

6, How does open fresh air make you feel? _____

7, How do you feel near the sea or mountains? _____

8, Any particular items of food/drink which adversely affect you or make you feel sick? _____

_____

9, How do you feel in closed, crowded places? (i.e. elevators, etc)_____

_____

10, How do you react to exertion, physical strain or mental strain? _____

_____

11, How do you function with a lack of sleep? _____

12, In what part of 24 hours do you feel your best and or your worst? _____

_____

13, How do you react when you are fasting? _____

_____

14, Do your troubles tend to occur or become worse, periodically? (i.e. daily, alternated days, every week, yearly, during new or full moons etc)_____

_____

STOOL / BOWEL MOVEMENTS

Do you regularly have a satisfactory bowel evacuation? _____

How many times do you move your bowels a day and at what time of day? _____

_____

Consistency (please circle one) well formed / semi-formed / very hard / loose

Odour _____ Colour of stool _____

Any straining required during bowel movements? _____ Do you suffer from constipation? _____

Any urgency for stool? (i.e. do you have to run for the first bowel movement of the day or immediately after eating)

_____

Do you have any pain, burning or bleeding with bowel movements? _____

Do you have? (Please circle) piles / fissures / fistulas

Do you have gas when passing stool? (Please circle) yes / no

URINE

What is your frequency of urination during the day and at night? _____

_____

Do you have any burning during urination? _____

Any odor to the urine? _____ Any difficulty in passing urine? _____

Any difficulty in retaining urine? _____

Do you have any incontinence while coughing or sneezing? _____

Do you have to run to the bathroom with urgency or the urine will escape? _____

Any associated complaints with urination? _____

_____

ADDITIVE HABBITS

Kindly elaborate and mention all habits, as well as addictions like food, alcohol, tobacco, recreational drugs, etc.

_____

_____

_____

_____

_____

_____

_____

_____

SEXUAL SPHERE

For Men

Any sexual disturbances? _____

Any excessive desire or aversion to sex? _____

Any disability of performance, premature ejaculation, etc? _____

_____

Any night time seminal emissions? _____ Any complaints after intercourse? _____

_____

Any history of sexual abuse, excessive masturbation, etc? _____

_____

For Women

Any sexual disturbances? _____

Any excessive desire or aversion to sex? _____

Any vaginal discharge itching, burning or discomfort associated? _____

_____

Any sense of 'bearing down' at the time of menses? _____

Any history of sexual abuse, excessive masturbation, etc?_____

_____

PREGNANCY

How many times have you been pregnant? _____

How many children do you have and their ages? _____

Did you have smooth pregnancies? _____

_____

_____

Did you take any medication during pregnancy? _____

Did you have normal deliveries? _____

_____

_____

MENSTRATION

How old were you when your period started? _____ Are your periods regular or irregular? _____

_____

What is the duration of your period? _____ How many days in your cycle? _____

How is the menstrual flow? (Please circle) scanty / heavy / clotted / odour

If there is an odour what does it smell like? _____

What is the colour of the flow? _____

PMS

Do you have any complaints associated with, before or after menses? (i.e. moods, headaches, irritability, anger, weeping, depression, diarrhoea or constipation) _____

_____

Any changes in your skin around your menses? _____

Any heaviness or pain in breasts before, during or after menses? _____

_____

MENOPAUSE

Age of menopause _____

Any associated complaints at the time of menopause? (i.e. hot flashes, palpitation, anxiety, depression etc)

_____

_____

_____

PRESPIRATION

Do you perspire a lot? _____

Any particular part of your body that you perspire more on? _____

Any strong / offensive odour associated with your perspiration? (i.e. sour smell with the sweat)

_____

Does the perspiration stain your clothes or your sheets and if so what colour? _____

_____

SLEEP

Do you sleep well? _____

Any particular posture in which you lie the most when you sleep? (i.e. lying on a particular side, on your back, stomach, curled up etc) _____

Do you feel refreshed after sleep? _____ Do you dream while sleeping? _____

Any particular dream that is recalled and often repeated? (i.e. frightening dreams of falling from heights, being pursued by someone, of dead people or relatives, etc)

_____

_____

_____

_____

Does any of your complaints get worse or better before, during or after sleep? (i.e. cough or asthma attacks that wakes you up at night or migraine on waking in the morning, hot flushes just as you begin to fall asleep, etc)

_____

_____

_____

_____

_____

Skin

Do you suffer from any skin problems or did you in the past? (i.e. allergies, eczema, fungal infections, pigmentations, acne, etc)

_____

_____

Any itching or discoloration associated with it? _____

_____

Any factors which worsen the skin problems? (i.e. food, any weather conditions or washing with warm or cold water, etc)

_____

_____

If so was there any treatment prescribed by a health care practitioner and what was the treatment?

_____

_____

Do you have any complaints or abnormality of your nails or the skin around your nails? _____

_____

Any complaints of hair falling out, early greying, dandruff, thinning etc? _____

_____

Any warts, moles, birth marks on your body? _____

_____

Does your skin heal normally after an injury or does it take a long time to heal? _____

_____

Do you have any tendency to form excessive scar tissue? _____

Do you have any tendency for wounds to suppurate (pus) easily? _____

_____

THE MIND

It is very important to give as much detail as possible in this section

Have you noticed any marked changes in your mental state lately? If so, describe it in detail.

_____

_____

_____

_____

_____

1, Have you become or are you anxious / afraid of anything? (i.e. being alone, animals, darkness, disease, thieves, robbers, etc)

_____

_____

2, Do you get startled easily by sudden noises, telephone ringing, banging of doors, etc?

_____

_____

3, Are you suspicious and doubting of people or situations? _____

_____

4, Are you impatient, hasty or a hurried person? _____

_____

5, Do you offend easily? (cannot take any criticism) _____

_____

6, Are you critical of others, always finding fault? _____

7, Are you irritable, quarrelsome, violent, etc? _____

8, Are you easily depressed, sad or gloomy? _____

9, Are you timid, shy or bashful? _____

10, Are you anxious, restless, nervous or excitable? _____

11, Are you a jealous or suspicious person? _____

12, Do you feel very anxious and apprehensive before examinations, stressful situations, and public engagements, etc?

_____

13, Are you quiet and reserved or are you talkative and make friends easily? _____

_____

14, Are you very affectionate? _____

15, Do you demand love and warmth form others? _____

16, Do you cry easily, if so what makes you cry? (i.e. grief of others, music, kind words, etc)_____

_____

17, Are you very sympathetic in general and go out of your way to help people in need? _____

_____

18, Are you easily moved to tears at the plight of others? _____

19, If someone consoles you when you are upset, does it help or does sympathy towards you make the matter worse?

_____

20, Are you an authoritative person, always in command and giving orders and expecting them to be followed by everyone around you?

_____

21, Do you have any fears or feelings for example that someone might want to harm you, hurt you or people may be against you?

_____

_____

22, How is your memory, power of concentration and mental ability? _____

_____

23, Do you feel humiliated or easily hurt? _____

24, Do any physical complaints arise out of feeling humiliated or easily hurt? _____

_____

25, Are you overly conscientious about details, cleanliness, tidiness, punctuality, etc?

_____

_____

26, Are you a perfectionist by nature, being meticulous, fastidious and even finicky? _____

_____

27, What is the greatest grief that you have ever felt in your life?

_____

28, What is the greatest joy that you have ever felt in your life?

_____

29, Can you mentally relax easily? (i.e. can you switch your mind off after work, problems, your children)

_____

30, Do you enjoy vacations? _____

31, Can you totally relax when on holidays or do your thoughts or work or what is happening at home keep bothering you etc?

_____

32, At work how do you associate with colleagues, subordinates, and your boss?

_____

33, Would being reprimanded or scolded from them upset you tremendously and how so?

_____

_____

34, What do you think is the biggest misconception about you?

_____

_____

35, Do you have a philosophy in which you live by?

_____

_____

36, Please finish this sentence

(Your name).....is

_____

_____