

# Kailo Homeopathy

www.kailohomeopathy.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)

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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

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Schizophrenia \_\_\_\_\_

Anxiety Neurosis / Depression \_\_\_\_\_

Any other sickness not mentioned above?

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## 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? \_\_\_\_\_

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### DIGESTION

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

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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) \_\_\_\_\_

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## THIRST

How thirsty are you?

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? \_\_\_\_\_

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## 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?

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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?

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

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

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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?

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

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

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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?

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13, How do you react when you are fasting?

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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)

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## **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?

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Consistency

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)

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

Do you have?

Do you have gas when passing stool?

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## **URINE**

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

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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?

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## **ADDITIVE HABBITS**

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

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## **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?

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## **MENSTRUATION**

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

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

How is the menstrual flow?

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)

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Any changes in your skin around your menses? \_\_\_\_\_

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

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## **MENOPAUSE**

Age of menopause \_\_\_\_\_

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

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## **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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

## Skin

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

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Any itching or discoloration associated with it?

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

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

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

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

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Any warts, moles, birth marks on your body?

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

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Do you have any tendency to form excessive scar tissue? \_\_\_\_\_

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

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## 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.

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

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

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

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

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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 from 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?

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23, Do you feel humiliated or easily hurt? \_\_\_\_\_

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

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

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

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

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

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

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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?

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

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

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

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

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36, Please finish this sentence

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(Your name).....is

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