

Active Homeopathy Intake / Questionnaire form for Homeopathic Consultation

Adapted from Dr. Rajan Sankaran original form with some modification for use by Active Homeopathy.

Ver: 092010

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have chosen homeopathy to get well. We are here to select the possible medicine for you. In order to do that, we depend on your co-operation. HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental makeup.

This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order to find all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is useless. Even something that you may think is not connected with your trouble may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give us the fullest possible information on each point.* Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential. When necessary please use additional blank paper to describe questions.

THIS QUESTIONNAIRE HAS 8 PARTS:

1. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
2. History of your present illness.
3. About all the parts of your body.
4. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
5. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.
6. About your sleep and dreams.
7. For children or how you were as a child.
8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

CONFIDENTIAL

PLEASE PRINT

Date: _____

Name: _____

Age: _____ Sex: Male / Female D.O.B.: _____

Height: _____ Weight: _____

Education: _____

Telephone Numbers: _____ Residence: _____

Office: _____

Mobile: _____

E-mail: _____

Marital Status: Single / Married / Divorced / Widowed

Home Address: _____

Occupation (Nature of Work): _____

Employer: _____

Business/Work Address: _____

City, State, Zip: _____

Person to be contacted in case of emergency: _____

Relation to Client: _____

Phone #: _____

Address: _____

Referred to us by: _____

PREVIOUS DISEASES & DRUGS USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus your body is strengthened. Thus it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illness so far suffered and on the next page give its relevant details.

Typhoid Cholera Food poisoning Worms Diarrhea Dysentery	Measles German Measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver, Spleen, or Gall bladder disease	Miscarriage Abortion Currettings Sickness during Pregnancy etc. Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Any venereal disease like Syphilis Gonorrhoea etc.	Any heart trouble, Blood pressure, Giddiness	Nephritis (Kidney or urinetrubble) Diabetes etc. Prostate trouble
Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles, Uterus, Renal stones, Gall stones, Phimosis, Hydrocele, Cataract etc. Mode of anesthesia: general or local	Diphtheria, Septic Tonsils, Adenoids, Recurrent infections-Sinusitis, Bronchitis-Eosinophilia Cold-Fever-Chill. Pneumonia Asthma-Pleurisy-T. B.		Any serious shock, grief, disappointments, fright, mental upset, depression or nervous break down.
Chronic Headaches, Numbness, Cramps, Fits, Convulsions Polio, Paralysis etc. Meningitis – Any Lumbar puncture done.	Any major accident or injury to body or head. Any occasion of unconsciousness. Any major bleeding from any part of the body.		Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Herpes, Urticaria, Allergy. Ulcers on any part of the body.

Diseases suffered from	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Please add any extra remarks or information:

Please indicate any drugs, tonics, stimulants etc. that have been used by you at any time in life:

FAMILY INFORMATION

List of major diseases	Relationship	Alive / Dead	Age	Diseases suffered	Cause of death	
Anaemia Cancer Diabetes Insanity Rheumatism T. B. / Pleurisy Leprosy Epilepsy / Fits Bleeding tendency Urticaria Eczema Asthma Paralysis Hypertension Heart trouble Kidney disease Liver disease List others:	Paternal Grand Father					
	Paternal Grand Mother					
	Maternal Grand Father					
	Maternal Grand Mother					
	Father					
	Mother					
		Diseases suffered				
	Paternal Uncle					
	Paternal Aunts					
	Maternal Uncle					
	Maternal Aunts					
	Cousin, Brother & Sister on Father's Side					
	Cousin, Brother & Sister on Mother's Side					
	Did any of your relatives have trouble similar to yours?					

How many brothers - sisters are you? (including those who died, if any). Provide information about them in the table below, Indicate your position by writing 'SELF'.

No	Brother / Sister	Alive / Dead	Age	Diseases Suffered
1				
2				
3				
4				
5				
6				
7				
8				

PERSONAL HISTORY

ABOUT YOUR BIRTH:

Did your mother have any problem during pregnancy?	
Did she take any drugs during pregnancy? What were they?	
Was there any difficulty about your birth? Give Details.	

AT WHAT AGE DID YOU START:

Teething		Urine control / bed-wetting etc.	
Sitting		Eating indigestible like chalk, lime, earth, slate-pencil etc.	
Standing		Any other problem about your growth & development?	
Walking			
Speaking			

Circle if any animal bites such as: **Dog Rat Snake Scorpion**

Mention if any order:

Did you take anti-rabies or anti-venom or any other treatment?

VACCINATION & INOCULATIONS

Indicate number of times you were vaccinated for the following:

Small-pox	Polio	Cholera	Measles
Triple	B. C. G.	Typhoid	Tetanus

Was there any reaction or particular trouble after any of above vaccination or inoculations? Give details.

(If married) How is the health of your husband/wife?

Number of children living and dead. If dead, state causes. Mention ages of children and their condition of health.

Child's Name	Male/Female	Age	Disease Suffered

Any abortions, miscarriages or still births?

Your Habits	How much?
Smoking	
Snuff	
Chewing tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives / Purgatives	
Any non-prescription Drugs	
Any other	

APPETITE AND THIRST

Question	Your Answer
How is your appetite?	
When are you hungry?	
What happens if you have to remain hungry for long? How fast do you eat?	
How much thirst do you have?	
Any particular time are you specially thirsty?	
Do you feel any change in your taste and feeling in your mouth?	

Please put one check (✓) if you **Like / Dislike** the food or if the food **disagrees**. Put two marks (✓✓) if you **strongly Like / Dislike** the food or if the food strongly **disagrees**.

	Like	Dislike	Disagrees
Bitter			
Salt extra			
Sweet			
Sour			
Bread			
Butter			
Fats			
Milk			
Coffee			
Mud / Chalk			

	Like	Dislike	Disagrees
Eggs			
Spicy food			
Meat			
Fish			
Cabbage			
Onions			
Warm food / drink			
Cold food / drink			
Fruits			
Anything else?			

STOOL

Questions	Your Answer
Do you have any problem regarding your stools?	
When and how many times a day you pass stools?	
When is it urgent?	
Do you have any problem about bowel movements?	
Do you have to strain for stool? Even if soft?	
Do you have belching or passing gas? Describe its character.	
How do you feel after passing gas up or down?	

URINATION & URINE

Questions	Your Answer
Any problem about urine?	
Any strong smell? Like what?	
Do you have any trouble before, during and after passing urine?	
Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling etc.?	
Any involuntary urination? When?	

SWEAT / PERSPIRATION - FEVER – CHILL

Questions Related to Temperature	Your Answer
How much do you sweat?	
Where and on what part do you sweat most?	
Do you perspire on the palms or soles?	

Questions Related to Temperature	Your Answer
Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?	
What is the smell like ? e.g. foul, pungent, sour, urinous.	
What color does it stain the clothing?	
Is the stain easy to wash off or difficult?	
Any symptoms after sweating?	
When do you get fever or chill?	
What brings it on?	
Do you experience any sense of heat or cold in any part of your body at any particular time?	
Do you have burning or heat in your palms or soles?	

CHEST - HEAT - COLD - COUGH

Questions	Your Answer
Do you catch cold often? If so, how?	
Describe the symptoms, nature of discharge etc. Is there any trouble with your CHEST or HEART?	
Is there any trouble with your voice or speech?	
Is there any difficulty in breathing?	
Do you have cough?	
Is the cough more at any particular time?	

SEXUAL SPHERE (GENERAL)

Questions	Your Answer
Any excessive indulgence in sex in past and present? Any effect on your health?	
How do you feel after sexual intercourse?	
Any particular feeling or symptoms appear before, during or after sexual intercourse?	
Do you suffer from any sexual disturbance ?	
Any habit like (masturbation etc.) in past as well as present? How often?	
Any homosexual inclination?	
Did you suffer from any sexually transmitted disease? Syphilis? Gonorrhoea? Herpes? HIV?	
Did you have increased desire or decreased desire for sex?	
What is the method you use for family planning (contraception)?	

FOR MEN

Questions	Your Answer
Any difficulty in erection?	
Wanted erection? Unwanted erection? Describe.	
Weak erection? Failing erection?	
Any other trouble in sex? Describe in details.	

FOR WOMEN

Questions	Your Answer
Menses: How are the periods; regular or irregular?	
At what age did you start?	
Was there any trouble then?	
What is the interval between two periods?	
Mention number of days of flow.	
Menstrual flow: Is there any change now in quantity, color, smell or consistency ?	
Are the stains difficult to wash?	
Have you noticed any variation in quality and quantity of flow during menses? How and when?	
Do you suffer in any way before, during or after menses? If so, describe	
What symptoms did you suffer during menopause?	
Do you feel internal parts coming down?	
Is there any white discharge?	
If so, mention the nature, color, consistency and smell of discharge.	
When and under what circumstances is it more or less. Has the discharge any relation to menses?	
What is the effect of this discharge on your general feeling? Or any of your symptoms?	
Any itching, excoriation etc. due to discharge?	
Do you pass any gas from vagina?	
Any trouble with breasts?	

ANY COMPLAINTS ABOUT:

Questions Related to Complaints	Your Answer
VERTIGO - Do you have giddiness - vertigo?	
FAINTNESS: Do you ever feel faint?	
HEAD: Do you get headaches?	
EYES & VISION	
EARS & Sense of hearing	
NOSE & Sense of smell	
FACE & Facial expression	
MOUTH & Sense of taste	
About LIPS, MOUTH, TONGUE etc.:	
TEETH, GUMS, e.g. carious teeth, bleeding gums. Swollen gums.	
LIPS : Cracked, peeling of skin etc.	
THROAT (including tonsils) Any difficulty in swallowing?	
Do you have any trouble in your BACK, LIMBS OR JOINTS? Describe in detail	
If you have pains, do they shift? In what direction do they extend?	
Is there any abnormality, swelling, numbness, paralysis etc. in any part of the body?	
Is there any complaint of SKIN: such as itching, eruptions ulcers, warts, corns, peeling etc.? (Describe its nature)	
Any change in color of the skin or spots of any part of the body?	
Is there any complaint or abnormality of the NAILS or skins around?	
Is there any complaint with the HAIR	

Questions Related to Complaints	Your Answer
such as falling, graying, dandruff, dryness, oily , poor excessive or unusual growth?	
Do wounds heal slowly?	
Form keloid? Do wounds tend to form pus? Have you a tendency to bleed?	
Are your troubles one sided? Which one ? Or more on one side?	
Do they proceed from one to the other side? Or do they alternate or shift?	
Is there any trembling? When?	
Is there any sense of weakness? Where? When is it more or less?	
Is it in any particular part of the body?	

FACTORS THAT AFFECT YOU

Below are the list of things that you are exposed to each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of the factors? In what way do they affect you?

For instance take the factor "sun". Suppose by going in the sun you get a headache then write "Headache" opposite to "Sun".

Take another example If in hot weather you feel uneasy, then write "Uneasy" opposite to "Hot Weather" in the column.

In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to "lying on the back" write "Asthma becomes worse".

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause headache but make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

Condition	Effects
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunder - storm	
Covering	
Warm bath	

Condition	Effects
Sun	
Cold bathing	
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding in bus, car etc.	
Lying	

Condition	Effects
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	
Lying with head low	
Sitting	
Sitting erect	
Standing	
Looking up	
Looking down	
Looking from high places	
Looking from moving object	
Noise	
Sudden Noise	
Music	
Light	
Strong smells	
When constipated	
Before Urine	
During Urine	
After Urine	
Before Menses	
During Menses	
After Menses	
After Sweating	

Condition	Effects
When Fasting	
After eating	
Drinking	
After sexual intercourse	
Dust	
Smoke	
Touch	
Pressure	
Massage	
Tight Clothes	
Before Sleep	
During Sleep	
After Sleep	
After afternoon nap	
Loss of sleep	
Before stools	
During stools	
After stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	

Condition	Effects
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After Weeping	
Consolation / Sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Full Moon / New Moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Biting or chewing	
Blowing Nose	
When alone	
In company	
Physical exertion	
Belching	

Condition	Effects
Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Moonlight	
Opening the mouth	
Smoking	
Hanging the limbs	
Raising the arms	
Near Sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Over eating	
Working in water	
Fanning	

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole.

In order to understand you, we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental makeup.

ANSWER FREELY. ANSWER FRANKLY. ANSWER COMPLETELY.

Question Related to Mind	Your Answer
Are you anxious? About which matters?	
Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.?	
Are you doubtful or suspicious? Of what?	
What are you jealous about?	
Of whom are you jealous? From what symptoms do you suffer when jealous?	
In which matter are you impatient? Hurried?	
How long do you remember hurts caused to you by others?	
How much revengeful are you?	
What are you proud of? Does your pride get easily hurt?	
Depress, Brooding, etc.?	
Do you ever become suicidal? When? If so in what manner do you	

Question Related to Mind	Your Answer
contemplate to end your life?	
Even then, are you afraid of dying?	
When are you cheerful?	
Are you sexual-minded?	
Any unwanted thoughts any time? What are they?	
Have you any imaginary sensations or fears?	
Do you hear voices, or that you are called, or anything else in this line keeps on occurring in your mind unduly?	
How is your memory? For what is it poor? e.g. names, places, faces, what you have read, etc.	
Do you weep easily?	
What makes you weep?	
How do you feel after weeping?	
How do you feel if someone offers sympathy and consolation?	
Are you easily irritated? What makes you angry?	
What bodily symptoms do you develop when angry? e.g. trembling, sweating etc.	
Do you like company? Or like to remain alone?	
How seriously are you affected by disorder and uncleanliness in your surrounding?	
What are the greatest griefs that you have gone through in your life?	
What are the greatest joys that you have had in life?	

Question Related to Mind	Your Answer
What activities you deeply like?	
Are there any matters which you deeply dislike?	
In your opinion, which aspects of your mind and moods are not agreeable to you. In spite of your awareness and maturity, are you unable to change these aspects?	
How does the future look to you?	
When you are free, what thoughts come to your mind?	

Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.

Are you worried or unhappy over any personal, domestic, economical, social or any other condition? If so describe in detail.

If asked for 3 desires or wishes in life, what will you ask for?

SLEEP

Question	Your Answer
Describe your posture in sleep, on the back, side, abdomen etc.	
Are you able to sleep in any position? In which position you can't sleep?	
During sleep do you: Snore? Grind teeth? Dribble saliva? Sweat? Keep eyes or mouth open? Walk? Talk? Moan? Weep? Become restless? Wake up with a jerk?	
Describe if anything else is unusual about your sleep: (sleepy, sleeplessness, etc. if so when?)	
How much do you cover?	
Do you have to uncover any parts?	

CIRCLE TYPES OF DREAM THAT YOU HAVE

Animals Cats - Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death, Whose? Dead bodies Dead persons Part of Body Suicide
Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work
Vomiting Passing stool Urinating Blood-bleeding Excrements / soiling	Romantic Sexual Pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure / Exams Unsuccessful efforts? For what? Missing Train/flight Being unprepared
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom? - For what?	If any other, please specify in this space:	
Of people: Children Parties Feasts Marriage	Of events: Remote Recent Future Prophetic	Physical Exertion Mental Exertion Fatigue Colored Multi-Colored		

**PLEASE DRAW SOMETHING THAT COMES TO YOUR MIND AT PRESENT OR
YOUR FAVORITE DRAWING**

FOR CHILDREN OR YOU AS A CHILD (IN CASE OF ADULT)

- 1- Please check mark once (✓) if the child or you as child had any of the following qualities : Check mark twice (✓✓) if they are/were more intense:

Condition	✓
Obstinacy	
Temper tantrums	
Disobedience	
Aggression	
Hyperactivity	
Destructiveness	
Courage	
Possessiveness	
Competition - winning spirit	
Sibling jealousy	
Any special skills	
Unusual desires (for what)	
Boasting	
Stealing	
Telling lies	

Condition	✓
Unusual fears	
Shyness	
Unusual attachments (to whom)	
Habits like :-	
Biting nails	
Thumb-sucking	
Picking and playing with	
(a) mother's body parts	
(b) shawls, handkerchiefs	
(c) anything else	
Religious	
Dullness of memory	
Slowness (in what)	
Laziness / Indolence	
Sensitive / Emotional	

- 2- Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also describe the dreams the mother got during pregnancy.

- 3- Please describe any other aspects you feel are striking about the child.

- 4- Describe one incident from the child's life when he/she very upset.

HOW TO DESCRIBE YOUR COMPLAINTS

In homeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homeopathic physician "I have a headache", "an eruption", or "cough", would not be enough. If you inform him "I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool", then only you have given all the information required for making a good homeopathic prescription. *The success of the prescription depends, largely, on how detailed is your description of the symptoms.*

We require the following details about your symptoms:

LOCATION: Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on **page 28** to indicate location.

SENSATION: Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning, jerking, pressing. Express the sensation or pain as it feels to you.

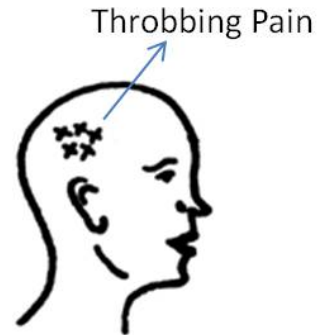
WHAT MAKES YOU WORSE OR BETTER: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on **pages 17 to 19**. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES: You may have a discharge from ulcers, fistula, eruptions on the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects.

- The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases?
- The consistency; Is it thin or thick, stringy, or clotted?
- Is it like jelly, white of an egg, like water, sticky, forming a scab etc.?
- The odor, what does it remind you of?
- Does it make the parts sore, and in what way?

BODY SIDES AND VIEWS FOR MARKING COMPLAINTS

Please mark on the figure below, the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of your head please mark as shown

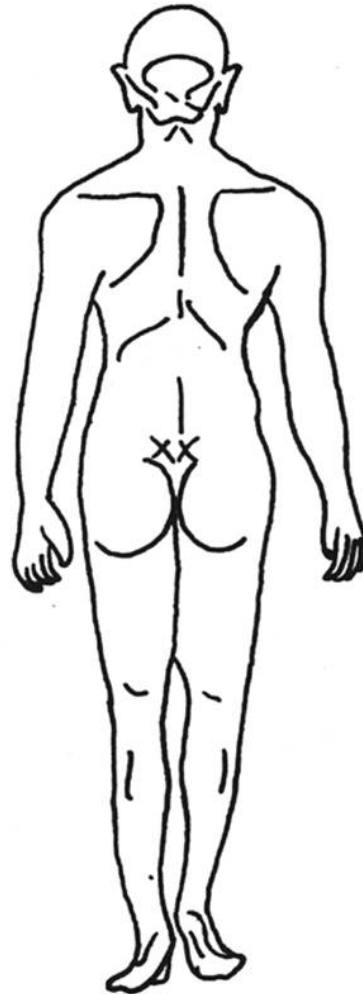
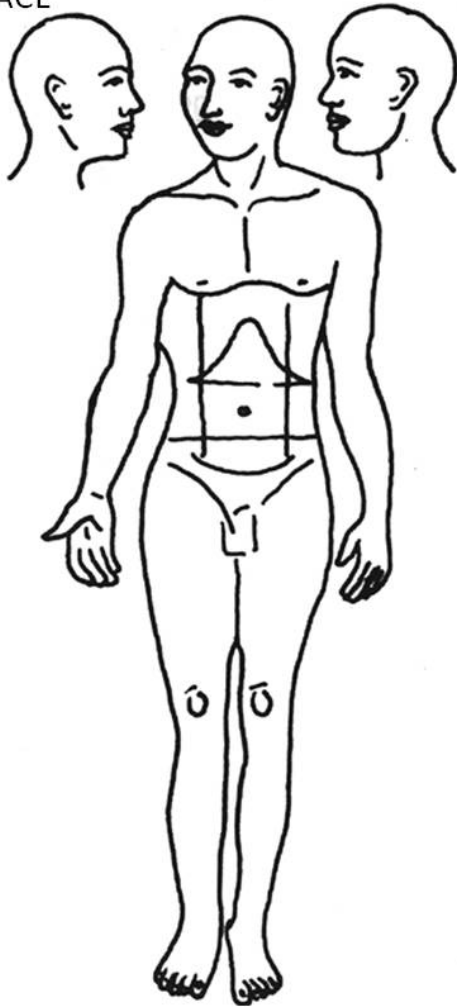


RIGHT
FACE

FRONT

LEFT
FACE

BACK



**IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS
IN DETAIL IN THE MANNER DESCRIBED ON PAGE 27**

COMPLAINT	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE

COMPLAINT	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE

