HOMEOPATHIC HEALTH PROFILE

Name_____ Age_____ Sex_____

Birthdate_____ Birthtime_____Place of Birth_____

Address _____

City _____ State _____ Country_____ Zip Code _____

Phone (home)_____ (work) _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Cohabitating _____

Live with: Spouse _____ Parents _____ Relatives _____ Friends _____ Alone _____ Other _____

Pets _____

_____

_____

What type of education do you have? _____

What profession or type of work do you do?_____

Occupation _____ Full or Part Time _____ Retired _____

Employed by:_____

Military Service: Where did you serve?_____

When did you serve?_____

Did you get injuries, vaccinations or treatments of any kind?

_____

_____

_____

_____

You have been referred by:

_____

HOMEOPATHY AND NATUROPATHIC THERAPY: Are you familiar with, or have you ever had Homeopathic or Naturopathic Therapies?

_____

_____

_____

YOUR CHIEF COMPLAINTS: In your opinion, what are your most important health problems? List as many as you can in order of importance:

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

Comments about your most important health problems:

_____

_____

_____

_____

_____

YOUR GENERAL HEALTH: On a scale of 1 to 10 how do you rate your health now? _____

The general state of my health has been: Excellent _____ Good _____ Fair _____ Poor_____

How is your general Vitality, Stamina and Energy? _____

Are you a warm or chilly person? _____ Are you a thirsty person? _____

Do you prefer cold or warm drinks? _____

YOUR HEALTH HISTORY: When did your complaint or ailment begin? _____

What do you think causes or has caused your ailment or complaint? _____

_____

_____

_____

Have you had an experience (traumatic or otherwise) that did or still does affect you deeply? _____

Explain: _____

_____

_____

_____

What childhood illnesses have you had and when did you have them?

Rubella (3 day measles) _____ Mumps _____ Measles (two week) _____

Chickenpox _____ Whooping Cough _____ Rheumatic Fever _____

Scarlet Fever _____ Polio _____ Asthma _____ Others _____

_____

If you have had any of the following tests or immunizations, place an (X) on the appropriate line and if you can, give the year you last had them:

Chest x-ray ___ _____ Smallpox ___ _____ Kidney x-ray (Pyelogram) ___ _____

Tetanus ___ _____ G.I. Series ___ _____ Colon x-ray (Barium enema) ___ _____

Polio ___ _____ Typhoid ___ _____ Mumps ___ _____ Flu ___ _____

Measles ___ _____ Rubella ___ _____ T.B. test ___ _____Electrocardiogram

___ _____ Gallbladder x-ray (Cholecystogram) ___ _____ Diphtheria ___ _____

Other x-rays _____

Other_____

HOSPITALIZATIONS: (List as best as you can) Type of illness/operation Date Where

_____

_____

_____

_____

Please mark 1 (mild), 2 (moderate), 3 (severe)

FAMILY HEALTH HISTORY: Please list ages, and if deceased, what they died of and at what age:

Relation	Living	Died	Cause	Age
Your mother	_____	_____	_____	_____
Your father	_____	_____	_____	_____
Your brother(s)	_____	_____	_____	_____
_	_____	_____	_____	_____
_	_____	_____	_____	_____
Your sister(s)	_____	_____	_____	_____
_	_____	_____	_____	_____
_	_____	_____	_____	_____
Mother's side: Your grandfather	_____	_____	_____	_____
Your grandmother	_____	_____	_____	_____

Father's side: Your grandfather _____ _____ _____ _____

Your grandmother _____ _____ _____ _____

Has any BLOOD RELATIVE had any of the following? YES NO DK (Don't know)

Allergies _____ Hay Fever _____ Anemia _____ Heart Attack _____ Arthritis _____ High Blood Pressure _____

Asthma _____ Seizure or Epilepsy _____ Bleeding _____ Sickle Cell Anemia _____ Cancer _____ Stroke _____

Diabetes _____ Thyroid Trouble _____ Depression _____ TB (Tuberculosis) _____ Eczema _____ Gout _____

V.D. (Gonorrhea, Syphilis) _____ Glaucoma _____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST:

CARDIOVASCULAR SYSTEM: Chest Pain when Walking _____ _____ Leg Vein Troubles _____ _____

Ankle Swelling _____ _____ Leg Pain when Walking _____ _____ High Blood Pressure _____ _____

Shortness of Breath _____ _____ Heart Palpitations (fluttering, pressure skipping going fast) _____ _____

ENDOCRINE - HORMONAL SYSTEM: Excessive Hair Growth _____ _____ Prefer Cold Weather _____ _____

Cold Hands or Feet _____ _____ Can't Stand Cold _____ _____Prefer Hot Weather _____ _____ Can't Stand

Heat _____ _____ Increased Thirst _____ _____ Increased Hunger _____ _____ Chronic Fatigue _____ _____

Weakness _____ _____ Sweating, Excess _____ _____ Unexplained Weight Loss / Gain _____ _____

SLEEP AND DREAMS: Do you have any history of sleep problems, irregular sleep patterns? YES _____ NO

_____ If so, what problems? Sleepy during day? YES _____ NO _____ When? _____

Do you usually dream? YES _____ NO _____ Do you remember your dreams? YES_____ NO _____

Is there a recurring theme to your dreams? YES _____ NO _____ If so what? _____

_____

_____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST:

Insomnia, Sleeplessness _____ _____ Nightmares / Bad Dreams _____ _____ Wake Unrefreshed _____ _____

Too Hot or Cold During Sleep _____ _____ Sleep Deprivation _____ _____ Night Sweats _____ _____

BLOOD, LYMPH, IMMUNE SYSTEM: NOW PAST: Swollen or Painful Lymph Nodes _____ _____ Chronic Fatigue

_____ _____ Wounds Heal Slowly _____ _____ Blood Transfusions _____ _____ Fevers or Chills _____ _____

Difficulty Stopping Bleeding _____ _____ Anemia, Tires Easily _____ _____ Bruises Easily _____ _____

Bleeding from Unusual Places _____ _____ Re-Occuring Infections _____ _____ Swollen Glands _____ _____

Unexplained Illness _____ _____

RESPIRATORY SYSTEM: NOW PAST: Unexplained Coughs _____ _____ Chest Pain when Breathing _____

_____ Mucus in Lungs _____ _____ Shortness of Breath _____ _____ Wheezing, Asthma _____ _____ Chronic

Cough _____ _____ Difficulty Breathing _____ _____ Lung Infections _____ _____ Tobacco Smoking _____

_____ Breathing at Night (wakes you up) _____ _____ How far can you walk or how many stairs can you climb before having to stop? _____What makes you stop? _____

_____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

NERVOUS SYSTEM: Loss of Balance _____ _____ Paralysis _____ _____ Convulsions, (seizures) _____ _____ Lack of Strength _____ _____ Tremor (shaking) _____ _____ Numbness _____ _____ Involuntary Movements _____ _____ Nerve Pain, Sensations _____ _____

SKIN AND HAIR: Skin Rough, Dry, Scaly, Bumpy, Itchy (circle) _____ _____ Pimples, Acne _____ _____ Warts, Moles, Cysts (circle) _____ _____ Boils, Abscess _____ _____ Light or Dark Patches of Skin (circle) _____ _____ Oily Skin _____ _____ Increased Hair Growth in Unusual Places _____ _____ Dry, Cracked Skin _____ _____ Age Spots _____ _____ Eczema _____ _____ Color Changes in Nails _____ _____ Dermatitis _____ _____ Hives, Rashes _____ _____ Sensitive Skin _____ _____ Loss of Hair _____ _____ Wrinkles, Premature _____ _____ Ridges, Pits or Spots on Nails _____ _____ Blackheads, Clogged Pores _____ _____ Infections _____ _____ Scars, Keloids _____ _____

DIGESTIVE SYSTEM: Acid Reflux _____ _____ Vomiting, Nausea _____ _____ Blood in Stools _____ _____ Diarrhea _____ _____ Constipation _____ _____ Fissures _____ _____ Change in Bowel Movements _____ _____ Anal Itching _____ _____ Black or White Stools _____ _____ Vomiting Blood _____ _____ Heartburn _____ _____ Gas and Bloating _____ _____ Excess Belching _____ _____ Yellow Jaundice _____ _____ Stomach Pain and Aches _____ _____ Trouble Swallowing _____ _____ Distress from Fats or Greasy Foods _____ _____ Worms, Parasites _____ _____ Stools Yellow; Clay-Colored; Foul-Odored; Undigested Foods _____ _____ Colitis _____ _____ Bad Breath; Bad Taste in Mouth; Body Odor (including feet) _____ _____ Surgeries, Injuries _____ _____ Indigestion after Meals; Fullness, Sourness, Etc. _____ _____ Poor Assimilation _____ _____ Heavy, Full Feeling after Eating _____ _____ Weight Gain or Loss _____ _____ Excessive Lower Bowel Gas _____ _____ Food Allergies _____ _____ Diarrhea or Loose Stools _____ _____ Stomach Pain Occurs 5 or 6 Hours after Eating _____ _____ Special Diets _____ _____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST

Indigestion occurs immediately after eating _____ _____ Nervousness, shaky feelings, headaches; relieved by eating _____ _____ Irritable if late for meal, miss meal, or before eating breakfast _____ _____ Sudden, strong craving for sweets or alcohol _____ _____ Wake up at night feeling hungry _____ _____ Overweight _____ _____ Loss of appetite _____ _____ Sudden weight loss _____ _____ Sudden weight gain _____ _____ Infection _____ _____ Injury _____ _____

How often do you have bowel movements? _____ Do you strain at stool? YES _____ NO _____

Have you had a change of appetite? YES _____ NO _____ Increase or decrease? _____

What does your diet consist of?

_____

_____

_____

_____

How frequently do you eat? _____ Who prepares your food? _____

Do you snack? YES _____ NO _____ On what? _____

_____

_____

What food(s), condiment(s), or any other substances (tobacco, alcohol, coffee, etc.) do you crave?

_____

_____

Are you repelled by, or do you dislike any foods? YES _____ NO _____ What Foods? (Please identify)

_____

_____

_____

Are there any foods that trouble or aggravate you? Do not agree with you? YES _____ NO _____ In what way?

_____

_____

_____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

UROGENITAL SYSTEM: Frequent Urination _____ _____ Painful Urination _____ _____ Night Urination _____ _____ Trouble Starting Urine _____ _____ Trouble Holding _____ _____ Blood in Urine MALE PROBLEMS: NOW PAST NOW PAST _____ _____ Have you ever had prostate problems _____ _____ Lumps, swelling or pain in testicles _____ _____ Discharge from penis _____ _____ Infection _____ _____ Difficulty achieving or maintaining an erection _____ _____ Infertility _____ _____ Painful erection _____ _____ Injury _____ _____ Difficulty with ejaculation_____ _____ What contraception do you use? _____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

FEMALE PROBLEMS: _____ _____ Discharge from vagina _____ _____ Pelvic pain _____ _____ Difficulty feeling sexually aroused _____ _____ Bleeding / spotting between periods _____ _____ No lubrication when aroused _____ _____ Lumps in breast _____ _____ Never or seldom have orgasms _____ _____ Infertility _____ _____ Menstrual flow is excessive/absent (circle) _____ _____ Sex is painful _____ _____

Pain before, during or after periods (circle) _____ _____ Infection - Location _____ when _____. _____ _____ Premenstrual symptoms: cramping, water retention, breast tenderness headaches, depression, irritability, others_____

_____

MENSES: Period every _____ days Regular? YES _____ NO _____ Period usually lasts _____ days (average) Number of tampons or pads used per day: _____ Date of last period: _____ Number of pregnancies: _____ Number of births: _____ Nursed children? YES_____ NO _____ How Many? _____ Any trouble with lactation? YES _____ NO _____ Number of miscarriages: _____ Number of abortions: _____

Dates:_____

Any complication(s) of pregnancy? YES _____ NO _____ If yes, please list: _____

_____

_____

How old were you when you started having menstrual periods? _____ Do you have any nipple discharge? YES _____ NO _____ What form of contraception do you use? _____

MUSCULOSKELETAL SYSTEM: Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST. NECK: stiffness _____ _____ whiplash _____ _____ pain, swelling _____ _____ injuries _____ _____

SPINE AND LIMBS: Muscle Cramps _____ _____ Burning of soles of feet _____ _____ Backaches _____ _____ Unusual redness of palms of hands _____ _____ Injuries _____ _____ Joint pain, swelling, stiffness, tingling, numbness_____ _____ Where?_____ _____ _____ Other _____

_____

_____

Have you ever had arthritis? YES _____ NO _____ When? _____

What kind?_____ Location?_ _____

_____

_____

Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.

HAIR: Dandruff _____ _____ Hair Damage from Treatments _____ _____ Hair Loss _____ _____ Dry Hair _____ _____ Baldness _____ _____ Oily Hair _____ _____

HEAD: Dizziness _____ _____ Migraines _____ _____ Severe Headaches _____ _____ Fainting Spells _____ _____ Seizures or Fits _____ _____ Nerve Pains _____ _____ Head Injuries _____ _____ Facial Paralysis _____ _____

EYES: Have you been diagnosed with any eye diseases? _____
Please mark 1 (mild), 2 (moderate) or 3 (severe) if any of the following apply to you NOW or in the PAST.
Eye Infections _____ _____ Poor Eyesight (near or far-sighted) _____ _____ Light hurts eyes _____ _____
Blurry Vision _____ _____ Double Vision _____ _____ Weak Vision _____ _____ Glaucoma _____ _____
Eyestrain _____ _____ Bloodshot Eyes _____ _____ Eye Injuries _____ _____
Do you have, or ever had floaters _____ _____

EARS: Discharge from Ears _____ _____ Ear Infections _____ _____ Pain in Ears _____ _____ Injuries _____ _____ Hearing Troubles _____ _____ Ringing in Ears _____ _____ Excessive Earwax _____ _____ Deafness _____ _____ Did you have experiences where you were exposed to very loud sounds _____ _____ Music _____ _____ Job related _____ _____ Military combat? _____ _____ How do you do in environments with lots of people talking, such as restaurants _____ _____ outdoor events_____ _____ Other _____
Do you wear hearing aids _____ _____

NOSE: Nosebleeds _____ _____ Difficulty in breathing through nose _____ _____ Mucus, Nasal Congestion _____ _____ Sensitive Smell _____ _____ Sinus Problems _____ _____ Post Nasal Drip _____ _____ Loss of Smell _____ _____ Injuries _____ _____

MOUTH: Sore Mouth or Tongue _____ _____ Bad Teeth _____ _____ Speech Difficulties _____ _____ Mouth Sores, Ulcers _____ _____ Loss of Teeth _____ _____ Toothaches _____ _____ Gum Bleeding _____ _____ Gums, Receding _____ _____ Gum Infections _____ _____ Tooth Cavities _____ _____

THROAT: Persistent Hoarseness _____ _____ Sore Throats _____ _____ Difficulty Swallowing _____ _____ Throat Sensations _____ _____ Loss of Voice _____ _____ Choking _____ _____ Laryngitis _____ _____ Throat Sores, Ulcers _____ _____ Mucus in Throat _____ _____ Swelling _____ _____

MENTAL AND EMOTIONAL: Anxiety, Excessive Worries _____ _____ Feel better from exercise _____ _____ Fears or Phobias _____ _____ Lack of motivation _____ _____ Nervousness, Restlessness _____ _____ Mental Fatigue _____ _____ Poor Self Confidence _____ _____ Trouble Sleeping _____ _____ Memory Trouble _____ _____ Trouble Concentrating _____ _____ Anger Spells, Irritable _____ _____ Crying Spells _____ _____ Worthlessness Feeling _____ _____ Depression _____ _____ Trouble getting along with people _____ _____ Feel like killing myself _____ _____ Mood Wings _____ _____ Easily Upset or Disappointed _____ _____ Obsessive Behaviors _____ _____ Loss of Emotional Control _____ _____ Brain Fog _____ _____ Panic Attacks _____ _____ Fearful of Public Speaking _____ _____ History of being abused _____ _____ Loss of someone dear through death or separation _____ _____ Emotional Shocks, Trauma _____ _____ Always put others interests before mine _____ _____ Suppressed anger or grief _____ _____ See things others don't _____ _____ Alcohol or drug addictions _____ _____ Hear voices _____ _____ Deep grief, hard to get over _____ _____ Think others want to hurt me _____ _____ Had excess stress in life _____ _____ Don't know how to life relieve stress _____ _____ Very sensitive emotions _____ _____ Are you generally late for

appointments?_____ _____ Very shy, timid _____ _____ Peculiar sensations. What?_____

_____

Where?_____

_____

To the best of your ability, list all major stressful or traumatic events in your life along with dates and timelines:

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Additional Comments: Is there anything else you wish to add? Also use the back of any pages if necessary.

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How would you like to improve on your general appearance, (Skin, hair, weight, teeth, etc)?

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NATUROPATHIC THERAPIES: Are you presently doing any of the treatments listed? YES AMOUNT:

Oil Pulling _____ _____ Detox Baths_____ _____

Herbal Teas/Tinctures_____ _____ Foot Baths_____ _____

Rasayana Tonics_____ _____ Herbal Teas/Tinctures_____ _____

Oil Massages_____ _____ Homeopathic Remedies_____ _____

Foot Oil Massages_____ _____ Homeopathic Cell Salts_____ _____

Breast Massages, (Women) _____ _____Natural Cosmetics_____ _____

Testes Tapping, (Men) _____ _____ Colonic / Enemas_____ _____

Qigong / Tai-chi / Yoga_____ _____Lucid Dream Therapy_____ _____

Qigong Self Massage_____ _____Inhalation Therapy_____ _____

Standing Meditation_____ _____Other Therapies_____

_____

_____

_____

Are you having any problems with the Naturopathic Therapy you are doing?

YES _____ NO _____ If so, what problems? _____

_____

_____

_____

_____

_____

_____

_____

_____

Have you noticed any changes in your general health since the Naturopathic Therapy?

YES _____ NO _____ If so, explain: _____

_____

_____

_____

_____

_____

Have you noticed old problems or symptoms getting better since the Naturopathic Therapy?

YES _____ NO _____ If so, explain:_____

_____

_____

_____

_____

_____

Have you noticed old problems or symptoms returning since the Naturopathic Therapy?

YES _____ NO _____ If so, explain: _____

_____

_____

_____

_____

_____

How is your sleep, vitality and mental/emotional state been since the Naturopathic Therapy?

_____

_____

_____

_____

Have you noticed any changes in your specific health problems since the Naturopathic Therapy?

_____

_____

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_____

Have you noticed any changes in your specific health problems since using any Homeopathic Therapies?

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Have you any further comments about the Naturopathic Treatments?

_____

_____

_____

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_____

_____

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_____

Please return with a current picture of your face and full body shot too:

meridiangrace@gmail.com or send hard copy to:

Meridian Grace

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Please feel free to check out YouTubes on awakeninghealth.com media link.