Abby Beale CCH RSHom(NA)

Certified Classical Homeopath

Office: 413-426-1024 ~ Cell: 203-530-3367 ~ HomeopathyHealings@gmail.com

Should you need to reschedule your visit or phone consultation, please contact me at minimum of one full business day in advance, to avoid the full office visit or phone consultation fee.

PLEASE NOTE: ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Some of the questions that follow may seem unrelated to your condition: they do however play a major role in getting a holistic view of your health situation. Please complete as much as you can and bring with you to your appointment.

PLEASE PRINT CLEARLY

Name _____ Date _____/_____/_____

Address_____ City_____ State_____ Zip_____

Cell: (____)_____ Other:: (____)_____ Email address:_____

Age:_____ Date Of Birth ____/____/___ Occupation _____ Referred by _____

In case of emergency notify _____Phone _____

Please list the main health problems you'd like help with, in order of importance:

1. _____
2. _____
3._____
4._____
5._____
6._____

Please check if YOU EVER have had ANY of the following			
☐	AIDS	☐	Kidney stones
☐	Positive test for AIDS/HIV antibodies	☐	Kidney or bladder infection
☐	Blood transfusions	☐	Liver disease
☐	Bone disease	☐	Low blood pressure
☐	Bronchitis	☐	Lupus
☐	Bursitis	☐	Malaria
☐	Cancer or tumor	☐	Measles
☐	Chicken pox	☐	Menstrual Cramps
☐	Colon/bowel disease	☐	Mononucleosis
☐	Allergies	☐	Mumps
☐	Anemia	☐	Pancreatitis
☐	Arthritis	☐	Pleurisy
☐	Asthma	☐	Pneumonia
☐	Diabetes	☐	Polio
☐	Diphtheria	☐	Prostatitis
☐	Drug habit	☐	Rheumatic fever
☐	Drug sensitivity or reaction	☐	Scarlet fever
☐	Emotional or mental problems	☐	Small pox
☐	Emphysema	☐	Spinal meningitis
☐	Gall stones	☐	Stomach or duodenal ulcer
☐	Gall bladder problems	☐	Tendonitis
☐	German measles	☐	Tuberculosis
☐	Heart trouble	☐	Thyroid or goiter trouble
☐	Heart murmur	☐	Typhoid
☐	Hemorrhoids	☐	Urinary Tract Infection
☐	Hepatitis/jaundice	☐	Varicose veins
☐	Herpes	☐	Venereal Disease
☐	High blood pressure	☐	Whooping cough
☐	Hives	☐	Yeast Infections

Self-Care Rituals - Feel free to elaborate after each.

- ☐ Good Sleep
- ☐ Aerobic Exercise
- ☐ Stretching
- ☐ Mindfulness/Stress Reduction Practices
- ☐ Healthy Eating
- ☐ Adequate Hydration
- ☐ Other: _____

Symptoms – Please **MARK** those symptoms **<u>you have ever experienced AND/OR are typical for you:</u>**

<u>General:</u>
Chills
Fevers
Sweat easily
Night sweats
Bleed or bruise easily
Acute sense of smell
Fatigue
Thirst for cold drinks
Thirst for ice cold drinks
Thirst for warm drinks

<u>Head, Eyes, Ears, Nose and Throat:</u>
Dizziness
Migraines
Headaches
Visual Aura Before Headache
Facial Pain
Night blindness
Blurry vision
Eye pain
Eye strain
Excessive tearing
Discharge from eyes
Poor hearing
Ringing in ears
Earaches/ Ear Infections
Discharge from ear
Nose bleeds
Sinus congestion
Grinding teeth
Jaw clicking
Concussions
Recurrent sore throat
Hoarseness
Sores on lips or tongue
Other:

<u>Respiratory:</u>
Cough
Asthma / wheezing
Pain with a deep breath
Difficulty breathing when lying down
Production of phlegm
Coughing blood
Pneumonia
Bronchitis
Other:

<u>Cardiovascular:</u>
High Blood Pressure
Low Blood Pressure
Chest discomfort / pain
Heart palpitations
Cold hands or feet
Swelling of hands
Swelling of feet
Blood clots
Fainting
Difficulty breathing
Other:

<u>Genital-Urinary:</u>
Pain when urinating
Urgency to urinate
Frequency of urination
Blood in urine
Decrease in flow
Leak urine/Dribbling
Kidney stones
Impotency
Change in sex drive
Sores on genitals/Herpes
Other:

<u>Gastrointestinal:</u>
Bad breath
Nausea
Vomiting
Heartburn
Belching
Indigestion
Diarrhea
Constipation
Blood in stools
Black stools
Abdominal pain or cramps
Gas
Rectal pain
Hemorrhoids
Other stomach or intestinal problems:

<u>Musculoskeletal:</u>
Neck pain
Shoulder pain
Back pain
Elbow pain
Hand / wrist pain
Hip pain

Musculoskeletal (con't)
Knee pain
Foot / ankle pain
Muscle pain
Muscle weakness
Other:

Neuro-Psychological
Seizures
Areas of numbness
Weakness
Sleep disorder
Concussion
Bad temper
Loss of control / violence potential
Vertigo
Lack of coordination
Depression
Stress
Loss of balance
Poor memory
Anxiety
Substance abuse
Suicidal
Other:

Skin and Hair:
Rashes
Itching
Hives
Eczema
Acne
Moles
Warts
Dandruff
Excessive loss of hair

Please list your most frequent childhood illnesses and usual treatment

Vaccinations (*check any that apply*)

□ Covid-19 and booster(s) (Pfizer, Moderna or JJ) _____

□ diphtheria/pertussis/tetanus(DPT)	□ measles, mumps, rubella (MMR)	□ chicken pox/varicella
□ tetanus booster	□ smallpox	□ HPV-2 or 3 shot series
□ flu vaccine	□ pneumonia vaccine	□ Shingles
□ polio	□ other _____	

Please list all current medicines and supplements

Family history (grandparents, parents, siblings) - *check any that apply and list family member(s) on blank*

□ cancer _____	□ diabetes _____	□ asthma _____
□ arthritis or gout _____	□ tuberculosis _____	□ heart disease _____
□ thyroid problem _____	□ kidney problems _____	□ eye disease_____
□ epilepsy _____	□ stroke _____	□ depression/anxiety _____
□ high cholesterol _____	□ allergies _____	□ bipolar disorder _____
□ high or low BP _____	□ alcohol/addiction _____	□ Other: _____

For Women Only

Past	Current	Symptom
☐	☐	Abdominal pain or cramping with menstruation
☐	☐	Abnormal PAP smear
☐	☐	Abortion
☐	☐	Back pain with menstruation
☐	☐	Birth control pills
☐	☐	Bleeding between periods
☐	☐	Bleeding during or after intercourse
☐	☐	Bloating before periods
☐	☐	Blood discharge from nipples
☐	☐	Breast lumps
☐	☐	Heavy bleeding with period
☐	☐	Hot flashes
☐	☐	Irregular periods
☐	☐	Irritability
☐	☐	Menopause
☐	☐	Miscarriage
☐	☐	Premenstrual tension/syndrome
☐	☐	Pregnancy
☐	☐	Scanty bleeding with period
☐	☐	Tubal ligation
☐	☐	Sickness/weakness with period
☐	☐	Vaginal discharge
☐	☐	Vaginal dryness or itching

~~~~~~

PLEASE do your best to complete the DATED Timeline on the separate page before we meet. We can fill in missing information as we go.

~~~~~~

Is there anything else you'd like me to know?

Thank you for helping me better understand your health situation. I look forward to seeing you soon!

Abby Beale CCH