

## Afton Family Homeopathy Health History

Thoroughly completing this form as best you can. Incomplete information makes it difficult to evaluate you as a whole person and even more difficult to find the right remedy to meet your unique needs.

**Name:** \_\_\_\_\_  
**Nickname:** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
**Preferred Phone # :** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_  
**Age:** \_\_\_\_\_  
**Gender:** \_\_\_\_\_  
**Height:** \_\_\_\_\_  
**Weight:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_

**Person financially responsible:** \_\_\_\_\_  
**Relationship to client:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_  
**Preferred Phone #:** \_\_\_\_\_  
**Email:** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_  
**Emergency contact phone #:** \_\_\_\_\_

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### CHIEF COMPLAINTS AND HOW THEY AFFECT YOU

Please state each complaint and how it affects your life.

1. \_\_\_\_\_  
\_\_\_\_\_
  
2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

Specifics of above complaints:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **SPECIFICS OF EACH COMPLAINT**

A. Describe the exact nature of the pain or sensation:

\_\_\_\_\_

\_\_\_\_\_

B. Describe the factors that affect or change your symptoms (For example: cold/damp/hot weather, food, posture/position, rest/motion, standing/sitting/lying/rising from chair, certain activity, pressure, hot/cold applications, movement, lying still, jarring, noise, etc)

\_\_\_\_\_

\_\_\_\_\_

C. Is there a time of day or season that is better or worse?

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D. Is there a specific food or drink that affect the complaint?

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E. How does sleep affect your complaint? (worse when getting up, worse lying, etc)

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F. Is there a sleep position that helps or makes it worse?

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G. How do your symptoms change before/during/after your period?

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H. Do your symptoms get better/worse with perspiration, vomiting, urination or bowel movement, sexual relations?

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I. Does anger/grief/fear/consolation affect your symptoms?

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J. Does the moon phase affect your symptoms

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K. Are there any other symptoms you feel somewhere else in your body when you feel your complaint? (For example: nausea with headache, tingling in arm during menses, cough when trying to have stool)

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L. Anything else you can think of to help describe this complaint that makes it unique to your body?

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### **DURATION OF COMPLAINTS**

For each complaint, please state when the complaint started:

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### **TREATMENT HISTORY**

Have you consulted a health professional? What, if any, diagnoses were made? What diagnostic tests were performed, where and when? (Providing a copy of these diagnostic tests is helpful) Please note that homeopathic care is not a replacement for the treatment/meds your doctor prescribes.

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What treatment/medication was recommended and/or used for this condition and when?

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### **TOTAL HEALTH PROFILE: HEAD TO FOOT**

Please include details of any issues you have with any body system (even if not listed).

#### **1. Head**

- Heat or burning? \_\_\_\_\_
- Perspiration? \_\_\_\_\_
- Vertigo or dizziness? \_\_\_\_\_
- Pain? (please note the above request for its character and what makes it better/worse) \_\_\_\_\_
- Other issues? \_\_\_\_\_

#### **2. Eyes**

- Pupils dilated or contracted? \_\_\_\_\_
- Blue rings? \_\_\_\_\_
- Swelling? \_\_\_\_\_
- Watering? \_\_\_\_\_
- Vision? \_\_\_\_\_

### **3. Ears**

- Any discharge? Thick or thin? \_\_\_\_\_
- Discharge color or odor? \_\_\_\_\_
- Ear infections or discharges from childhood? \_\_\_\_\_

### **4. Nose**

- Blocked nose? \_\_\_\_\_
- Which side? \_\_\_\_\_
- Discharge from nose? \_\_\_\_\_
- Thick, thin, color, smell of discharge? \_\_\_\_\_
- Irritation/burning in the nose or from discharge? \_\_\_\_\_

### **5. Mouth**

- Any odor from the mouth? \_\_\_\_\_
- Excess saliva? \_\_\_\_\_
- Taste in the mouth? \_\_\_\_\_
- Mouth ulcers? Frequency? \_\_\_\_\_

### **6. Teeth**

- Cavities now or as a child? \_\_\_\_\_
- Swollen gums? \_\_\_\_\_
- Bleeding gums? \_\_\_\_\_
- Grinding teeth? \_\_\_\_\_

### **7. Throat**

- Any pain? Which side? \_\_\_\_\_
- Swollen glands or tonsils? \_\_\_\_\_
- Mucus in the throat \_\_\_\_\_
- Need to hem/hawk to clear throat \_\_\_\_\_
- Does anything come up? Color, consistency? \_\_\_\_\_
- Difficulty swallowing or sensation in throat? \_\_\_\_\_

**8. Chest/Respiration**

- Cough? Dry or moist? \_\_\_\_\_
- What aggravates it?

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- When is it aggravated?
- 
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- What makes it feel better (without medication)?
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- Any breathing difficulty? \_\_\_\_\_
  - If you cough phlegm up, describe its look, texture, smell, if any? \_\_\_\_\_
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- Any other symptoms when you cough?

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**9. Heart/Circulation**

- Any palpitations? Pain, discomfort? \_\_\_\_\_
- What aggravates it and makes it better?

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**10. Stomach**

- Appetite?

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- When do you feel hungry?

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- Any acidity or discomfort? \_\_\_\_\_  
Any burning or heart burn?

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Nausea or vomiting? \_\_\_\_\_

**11. Abdomen**

- Any distension? \_\_\_\_\_
- Which part of the abdomen? \_\_\_\_\_
- Any belching? Does belching help? \_\_\_\_\_
- Does passing gas help? \_\_\_\_\_

- When does the distension occur? What makes it better?

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- Any pain? When does it occur? What makes it better?

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## **12. Bowels**

- How often do you have stools? \_\_\_\_\_
- Do you have an urge for stool but nothing happens? \_\_\_\_\_
- After a bowel movement, do you feel it did not all come out? \_\_\_\_\_
- Please describe the color, consistency of stool. \_\_\_\_\_
- Any blood, mucus, undigested food in stool? \_\_\_\_\_
- Any pain before, during or after stool? \_\_\_\_\_
- Any strong odor with stool? Please describe. \_\_\_\_\_

## **13. Rectum**

- Any trouble with your rectum? \_\_\_\_\_
- Pain? Burning? Discomfort? \_\_\_\_\_
- Hemorrhoids? Oozing? \_\_\_\_\_
- Bleeding? \_\_\_\_\_

## **14. Urine**

- Color and character or urine? \_\_\_\_\_
- Odor? \_\_\_\_\_
- Sediment? If so, color and consistency \_\_\_\_\_
- Do you pass urine a lot? (compared to others) How often? \_\_\_\_\_



- Any burning or discomfort? \_\_\_\_\_
- Any difficulty passing urine? \_\_\_\_\_

### **15. Perspiration**

- Any odor? \_\_\_\_\_
- Which body parts perspire?  
\_\_\_\_\_
- Does it stain? What color?  
\_\_\_\_\_
- Do you perspire more at night or when lying down? \_\_\_\_\_

### **16. Joints/Extremities**

- Describe any pain, giving location, what it feels like, where it radiates?  
\_\_\_\_\_
- Is this from a past injury?  
\_\_\_\_\_
- What makes it better or worse? (time, movement/rest, warm/cold applications)  
\_\_\_\_\_

### **17. Nails**

- Thick/thin? Break easily? \_\_\_\_\_
- Dry/glossy \_\_\_\_\_
- Ridged, wavy? \_\_\_\_\_
- Spots or stripes? \_\_\_\_\_
- Fungus? \_\_\_\_\_
- Concave, convex, spoon shaped? \_\_\_\_\_

### **18. Skin**

- Any skin disease? \_\_\_\_\_
- Discharge? Oozing? Color? Smell? \_\_\_\_\_
- Itching? \_\_\_\_\_

- Warts or moles? \_\_\_\_\_
- What makes itching worse or how does it get better?  
\_\_\_\_\_
- Any ointments, lotions, medicine used?  
\_\_\_\_\_
- Is your skin usually dry or oily or balanced between the two?  
\_\_\_\_\_
- Does your skin heal fast or do cuts tend to take a long time to heal?  
\_\_\_\_\_

**19. Reproductive System**

**Male**

- Any issues regarding sexuality/sexual function/libido you'd like to address?  
\_\_\_\_\_

**Female**

- Any issues regarding sexuality/sexual function/libido you'd like to address?  
\_\_\_\_\_
- Any issues with uterine prolapse or cervix?  
\_\_\_\_\_
- Menstrual cycle? Number of days? Clotting? Odor? Pain? If so, when?  
\_\_\_\_\_
- When did menstruation begin?  
\_\_\_\_\_
- When did menstruation end?  
\_\_\_\_\_
- Number of children? Miscarriage or terminations?  
\_\_\_\_\_
- Vaginal discharge?  
\_\_\_\_\_
- Breast pains/swelling?  
\_\_\_\_\_

- Were deliveries vaginal or C-section?
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## **20. Hot or Cold Blooded**

- What kind of climate do you prefer?  

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- What kind of climate do you hate?  

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- Do you desire fresh air?  

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- Would you enjoy vacation to a hot or cold climate?  

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- Which season do you like?  

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- Which season do you not like?  

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- Compared to others, do you wear more or fewer garments in winter?  

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- Which is unbearable for you: Summer (warmth) or Winter (cold) (Please do not correlate perspiration with this)  

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- In summer, do you like to have some warm covering at night or when asleep?  

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- If you could choose where to live for 5 years, the desert with sunny 95 degree dry weather, or Canada with sunny and 30 degree temperatures, or Florida with sunny and 90 degrees and humidity, where would you choose? (money, family, friends, work not an issue)  

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- You are going for a short walk on a crispy but cold day of 32 degrees. Your friend has on 4 layers of clothes with a glove and hat - how many layers are you wearing?  

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- Do you feel the cold and need the furnace warmer than most people desire?

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**21. Allergies** - please tell of your allergies, when you get them and if anything helps.

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**22. Food preferences** - please tell if you like, dislike, love or hate any of these foods.

Sweet: _____	Sour: _____	Salty/savory: _____	Sweet and sour: _____
Salt: _____	Bitter (like the bitter in bitter chocolate): _____	Fatty/greasy: _____	Rich food: _____

- Please indicate which of these you desire the most and least (this is your body's desire if you were not health conscious, NOT your actual diet):

Fish: _____	Meat: _____	Chicken: _____	Egg: _____
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- Please indicate which of these you desire most and least (this is your body's desire if you were not health conscious, NOT your actual diet):

Green leafy veggies	Salads	Cream	Ice Cream
Warm food: _____	Cold food that is normally served hot (like cold lasagne, cold curry, cold soup): _____	_____	_____

- Are there any foods you crave?

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### **23. Thirst Details**

- Do you prefer hot or drinks in general? \_\_\_\_\_
- Do you take long drinks when you drink? \_\_\_\_\_
- Do you take sips at regular intervals? \_\_\_\_\_
- Are you thirstless or have to remind yourself to drink? \_\_\_\_\_

### **24. Dreams**

- Do you have any recurrent dreams? What are they about even if nonsensical?

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- Did you have any recurring dreams as a child?

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### **24. Peculiarities**

- Can you think of any peculiarities in the way your body works that other people don't seem to have?

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### **25. General Nature**

- Do you tend to bleed easily or a lot? \_\_\_\_\_

If you get a cut, does it heal fast, slow, or get infected easily?

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- Do you have aches and pains in your body or joints?

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- Do your glands tend to get infected or swollen easily from cold or season changes?

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- Do your problems tend to be on the left or right side?

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**26. Past medical history and childhood illness** - please indicate if you have never been well or not as healthy since any prior illnesses.

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**27. Addiction?** Any issues with addiction?

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**28. Developmental milestones**

- When you were growing up, were there any delays in teething, walking, talking or other developmental issues?

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- Were there any emotional or physical traumas to you as a child? \_\_\_\_\_

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- Please state the vaccines you have had:

- 
- Did any of your current ailments begin after any particular vaccine?

- 
- Did you have any particular reaction after any of these vaccines?
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### 29. Family medical history:

- Any major illness/cause of death in close blood relatives?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Grandparents: \_\_\_\_\_

- Are you aware of any family tendencies to certain diseases?

\_\_\_\_\_

### 30. Pregnancy history

- Were there any significant occurrences to your mother while she was pregnant with you? \_\_\_\_\_

Asphyxia (lack of oxygen) _____	Birth injuries _____	Anxiety _____
Details about the delivery _____	Disappointment _____	Disease _____
Falls or accidents _____	Fears _____	Forceps _____
Fright _____	Grief _____	Medications _____

Normal vaginal delivery or C-  
Section\_\_\_\_\_

Shock\_\_\_\_\_

Repeated ultra-sounds\_\_\_\_\_

### 31. Sleep

- How much sleep do you get? \_\_\_\_\_
- How well do you sleep? \_\_\_\_\_
- Do you wake refreshed? \_\_\_\_\_
- If you wake in the night, is there a certain pattern to wakefulness?  
\_\_\_\_\_
- Are you able to fall back to sleep? If not, why not?  
  
\_\_\_\_\_  
\_\_\_\_\_

**32. Never been well since:** Is there anything that happened to you that still affects your life today? (Flu, shock, grief, measles, mumps, accident, fright, etc.) \_\_\_\_\_  
  
\_\_\_\_\_  
\_\_\_\_\_

**33. Any other details that might be important for us to know about?**  
  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PERSONALITY PROFILE

1. Please indicate from 1 to 3 which characteristics apply to you. 1 = a



little; 3 = a lot.

Absent minded _____	Active_____	Amiable/Friendly_____	Angry_____
Like Company_____	Energetic_____	Extrovert_____	Feel forsaken sometimes_____
Dislike Company_____			
Greedy/miserly (save every penny) _____	Hurried_____	Indifferent_____	Impatient_____
Impetuous/Impulsive - _____	Introvert_____	Irritable_____	Jealous_____
Methodical_____	Mild_____	Morose_____	Neat/clean_____
Negative/Pessimistic- _____	Organised_____	Positive/Optimistic_____	Punctual_____
Quarrelsome_____	Restless_____	Sentimental/Weepy- _____	Slow_____
Sluggish_____	Sociable_____	Stubborn_____	Suicidal_____
Suspicious_____	Sympathetic_____	Talkative_____	Untidy/messy_____

**2. Fears:** (accidents, animals, crowds, dark, death, dogs, snakes, spiders, heights, small spaces, sudden impulses, incurable disease, thunderstorms, etc) \_\_\_\_\_  
\_\_\_\_\_

### 3. Memory:

- How is your memory for recent events?

\_\_\_\_\_

- How is your memory for past events?

\_\_\_\_\_

- How is your concentration?

\_\_\_\_\_

### 4. Depression

- When did it start? Any particular cause you can think of?

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- When does it affect you? \_\_\_\_\_

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- When is it worse or better?

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- Any symptoms come with it?

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- Psychiatric care, treatment, medicines?

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## **5. Life Events**

- What was the happiest incident(s) in your life?

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- What was the saddest incident(s) in your life?

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- What are some of the most memorable incidents in your life? Why do these stand out?

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Abandonment_____	Sexual abuse_____	Violence_____	Being abused_____
Abusive spouse_____	Abusive parent_____	Mother's affection absent_____	Anger from neglect in childhood_____
Anger_____	Anticipation (effect on nerves) _____	Anxiety_____	Nervous of sudden violence as a child fears sudden beatings_____
Bad tragedies_____	Bereavement_____	Betrayal_____	Boredom_____
Business embarrassment_____	Contradiction_____	Criticism_____	Deceived friendship_____
Depressing emotion_____	Disagreement_____	Discords between boss and subordinate_____	Discord between friends_____
Discord between parents and children_____	Domination from foreign power, culture_____	Domination by parent_____	Domination_____
Embarrassment_____	Excitement, unusual_____	Failure in business_____	Failure_____
Fear_____	Feeling controlled_____	Friendship issues	Fright_____
Frustration - demands not fulfilled_____	Grief - long standing_____	Grudges_____	Trapped guilt
Wounded honor_____	Humiliation/criticized	Other humiliation_____	Indulgence_____
Insecurity in children needing parental care_____	Isolation_____	Jealousy_____	Joy_____
Loss of familiar ground_____	Loss of wealth or relationship_____	Conditional love_____	Unhappy love_____
Mental overexertion_____	Neglect and maltreatment as child_____	Bad news_____	Overstain, mental or bodily_____
Parental arguments_____	Parental control_____	Parental violence_____	Fit of passion_____
Past history, dominating mother, parents_____	Pressure to perform_____	Loss of possessions_____	Pride_____
prolonged history of unhappiness_____	Need for protection_____	Abuse by punishment_____	Quarrel_____

Rejection_____	Reproaches_____	Reserved displeasure_____	Restrictions_____
Reverses of Future_____	Ridicule	Rudeness of children_____	Rudeness of others_____
Scorned_____	Separation, isolation, unusual change in home/office_____	Separation_____	Shame_____
Socio-cultural stress_____	Horrible stories_____	Emotional stress_____	Stress of public performance_____
Terrors of alcoholic parent_____	Terrors of witnessing violence_____	Terrors of war_____	Traumatic childhood_____
Ugly, unloveable_____	Unfulfillment_____	Prolonged Unhappiness_____	Unloved_____
Unwanted_____	Unpleasant News_____	Violence, unpredicted mood of parent_____	Worry_____
Wounded (Sensitivity to ridicule) _____	Wounded honor_____	Wounded pride_____	

**6. Emotional factors that may have affected you and your life.** Please circle the issues below that you have experienced. If filling this section out is too emotionally difficult for you, we can wait until you are comfortable discussing. Sometimes unresolved emotional issues can show up as physical ailments.

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**7. Please give 10(ten) words that describe yourself:**

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**8. Which of the four categories below best describes you?** If no one category applies completely, check the characteristics that do apply.

- \_\_\_\_ Affectionate, avoid conflict, avoid risk, brood, caring, composed, conscientious, conservative, considerate, conventional, easy going, emotional, family oriented, fearful, friendly, generous, hesitant, home, honest, introvert, kind, lack confidence, lack motivation, loving, loyal, messy, mild, perceptive, private, reliable, reserved, safe person, sensitive, sentimental, shy, social, friendly, soft, sympathetic, thoughtful, timid, worrier, anxious, compassionate, amiable;
- \_\_\_\_ Absent minded, aggressive, ambitious, bossy, bubbly, careful, cautious, competitive, confident, dutiful, excitable, extrovert, follows routine, humorous, impatience, irritable, jealous, materialistic, optimistic, outgoing, passionate, perfectionist, planner, restless, romantic, selfish, serious, sincere, sociable, strong principles, strong sense of values, superstitious, want to please, workaholic
- \_\_\_\_ Desires solitude, negative attitude, resentful, pessimistic
- \_\_\_\_ Artistic, assertive, changeable, creative, discontented/bored easily, fault finding, fear insects and spiders, fun loving, independent, moaning, moody, precocious, stubborn, temper tantrums, whining, intolerant

**9. If you could take a week off work or school and money was no object, what would you do?**

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**10. If you could change one thing about yourself, what would it be?**

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**11. What are your hobbies or preferred leisure activities?**

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**12. What is most important to you?**

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**13. Do you worry about Family, Work, Money, Health, Safety, anything else?**

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**14. Your life summary - please detail any incidences that may have affected your life:**

• Age 0-10 years

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 10-20 years

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 20-30 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 30-40 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 40-50 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 50-60 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 60-70 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 70-80 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

• Age 80-90 years:

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

Diseases: \_\_\_\_\_

Drugs: \_\_\_\_\_

Feel free to list more here.

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