

# Homeopathy For Life

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Doctor of Natural Medicine  
Classical Homoeopath



Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Sex:  M  F Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Usual Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital status: \_\_\_\_\_ Number of children: \_\_\_\_\_  
 school  keeping house  work  full time  part time  unemployed  disabled  retired  
Referred by: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies); include type of illness, month and year hospitalized, name of hospital, city and state

#1: \_\_\_\_\_  
#2: \_\_\_\_\_  
#3: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications (Type, Dosage, Frequency): \_\_\_\_\_

Medicinal Herbs, Vitamins, Teas: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use:  Coffee: Amount \_\_\_\_\_  Cigarettes: Amount \_\_\_\_\_  
 Alcohol: Amount \_\_\_\_\_  Other drugs: Amount \_\_\_\_\_

<u>Tests</u>	<u>Year</u>	<u>Immunizations</u>	<u>Year</u>
Chest x-ray	_____	Smallpox	_____
Electrocardiogram	_____	Tetanus	_____
TB test	_____	Polio	_____
GI series	_____	Typhoid	_____
Kidney x-ray	_____	Mumps, Measles	_____
Barium Enema	_____	Flu	_____
Other x-rays	_____	Other	_____

If you have been bothered recently by any of these problems check yes:

- | Y N                           | Y N                             | Y N                          |
|-------------------------------|---------------------------------|------------------------------|
| ◇ ◇ frequent/severe headaches | ◇ ◇ recurring indigestion       | ◇ ◇ worry a lot              |
| ◇ ◇ back pains                | ◇ ◇ frequent belching           | ◇ ◇ scary dreams/thoughts    |
| ◇ ◇ neck lumps or swelling    | ◇ ◇ nausea                      | ◇ ◇ feeling of desperation   |
| ◇ ◇ loss of balance           | ◇ ◇ vomiting                    | ◇ ◇ shy or sensitive         |
| ◇ ◇ dizzy spells              | ◇ ◇ pain in abdomen             | ◇ ◇ dislike criticism        |
| ◇ ◇ blackouts/fainting        | ◇ ◇ bloated abdomen             | ◇ ◇ angered easily           |
| ◇ ◇ wear glasses              | ◇ ◇ constipation                | ◇ ◇ annoyed by little things |
| ◇ ◇ blurry vision             | ◇ ◇ loose bowels                | ◇ ◇ family problems          |
| ◇ ◇ eyesight worsening        | ◇ ◇ black stools                | ◇ ◇ problems at work         |
| ◇ ◇ see double                | ◇ ◇ grey or whitish stools      | ◇ ◇ sexual difficulties      |
| ◇ ◇ see halos or lights       | ◇ ◇ pain in rectum              | ◇ ◇ change of sexual energy  |
| ◇ ◇ eye pains or itching      | ◇ ◇ itching rectum              | ◇ ◇ considered suicide       |
| ◇ ◇ watering eyes             | ◇ ◇ blood with stools           | ◇ ◇ loss or gain in weight   |
| ◇ ◇ earaches                  | ◇ ◇ frequent urination          | ◇ ◇ loss of appetite         |
| ◇ ◇ hearing difficulties      | ◇ ◇ involuntary urination       | ◇ ◇ always hungry            |
| ◇ ◇ running ears              | ◇ ◇ burning on urination        | ◇ ◇ fatigue or weariness     |
| ◇ ◇ noises in ears            | ◇ ◇ black or bloody urine       | ◇ ◇ fever or chills          |
| ◇ ◇ dental problems           | ◇ ◇ weak urine stream           | ◇ ◇ motion sickness          |
| ◇ ◇ sore or bleeding gums     | ◇ ◇ difficulty starting urine   | ◇ ◇ night sweats             |
| ◇ ◇ sore tongue               | ◇ ◇ constant urge to urinate    | ◇ ◇ hot flashes              |
| ◇ ◇ congested nose            | ◇ ◇ aching muscles or joints    | ◇ ◇ warm or cold than others |
| ◇ ◇ running nose              | ◇ ◇ swollen joints              | <u>MEN ONLY</u>              |
| ◇ ◇ sneezing spells           | ◇ ◇ back or shoulder pains      | ◇ ◇ burning or discharge     |
| ◇ ◇ head colds                | ◇ ◇ weakness in arms/legs       | ◇ ◇ swelling on testicles    |
| ◇ ◇ nose bleeds               | ◇ ◇ painful feet                | ◇ ◇ painful testicles        |
| ◇ ◇ sore throat               | ◇ ◇ trembling                   | <u>WOMEN ONLY</u>            |
| ◇ ◇ difficulty swallowing     | ◇ ◇ numbness                    | ◇ ◇ missed period            |
| ◇ ◇ hoarse voice              | ◇ ◇ leg cramps                  | ◇ ◇ menstrual problems       |
| ◇ ◇ wheezing or gasping       | ◇ ◇ skin trouble                | ◇ ◇ bleeding btwn periods    |
| ◇ ◇ frequent coughing         | ◇ ◇ scalp problems              | ◇ ◇ heavy bleeding           |
| ◇ ◇ cough up phlegm           | ◇ ◇ itching or burning skin     | ◇ ◇ bearing down feeling     |
| ◇ ◇ cough up blood            | ◇ ◇ bruise easily               | ◇ ◇ vaginal discharge        |
| ◇ ◇ chest colds               | ◇ ◇ nervousness or anxiety      | ◇ ◇ genital irritation       |
| ◇ ◇ rapid/skipped heart beats | ◇ ◇ nervous with strangers      | ◇ ◇ pain on intercourse      |
| ◇ ◇ chest pains               | ◇ ◇ nail biting                 | ◇ ◇ swelling of breasts      |
| ◇ ◇ shortness of breath       | ◇ ◇ difficulty making decisions | _____ # of pregnancies       |
| ◇ ◇ swollen feet or ankles    | ◇ ◇ lack of concentration       | _____ # of births            |
| ◇ ◇ armpits or groin swelling | ◇ ◇ loss of memory              | _____ # of miscarriages      |
| ◇ ◇ difficulty sleeping       | ◇ ◇ lonely or depressed         | _____ # of premature births  |
| ◇ ◇ difficulty relaxing       | ◇ ◇ frequent crying             | _____ # of caesarean         |
| ◇ ◇ excessive sweating        | ◇ ◇ hopeless outlook            | _____ # of abortions         |

◇ ◇ Comments or special problems: \_\_\_\_\_

What are you most sensitive to (e.g. noise, odors, light, pain)? \_\_\_\_\_  
\_\_\_\_\_

Describe an ideal day in terms of weather and temperature: \_\_\_\_\_  
\_\_\_\_\_

What are your fears? \_\_\_\_\_  
\_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_  
\_\_\_\_\_

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your Favorite color? \_\_\_\_\_

Least favorite color? \_\_\_\_\_

How is your energy? Is there any particular time of day when it is lower or higher? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Women only) What symptoms do you experience premenstrual? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How is your sexual interest/drive? \_\_\_\_\_  
\_\_\_\_\_

What do you most like to eat or crave? \_\_\_\_\_  
\_\_\_\_\_

What foods do you most dislike? \_\_\_\_\_  
\_\_\_\_\_

How is your thirst? \_\_\_\_\_

What temperature do you like fluids? \_\_\_\_\_

Are there any foods that you are sensitive to or allergic to? \_\_\_\_\_  
\_\_\_\_\_

Family History: Place an X in the appropriate column for any illness that you or your relatives have had:

<b>Illness</b>	<b>Self</b>	<b>Father</b>	<b>Mother</b>	<b>Brother</b>	<b>Sisters</b>	<b>Child #1</b>	<b>Child</b>	<b>Child</b>	<b>Grandparents</b>
Abnormal periods									
Alcohol/Drugs									
Allergies									
Anemia									
Arthritis/Gout									
Asthma									
Bleeding problems									
Cancer									
Diabetes									
Eczema									
Emphysema									
Epilepsy									
Frequent infections									
Heart trouble									
Hepatitis									
High blood pressure									
Kidney problems									
Mental illness									
Migraines									
Polio									
Pneumonia									
Prostate problems									
Psoriasis									
Rheumatic fever									
Stomach problems									
Stroke									
Thyroid problems									
Tuberculosis									
Ulcers									
Venereal disease									
Weight problems									