Cathleen Springer, C.Hom.
Classical Homeopathy
Serving Sonoma County Since 2000
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Date_____

Referred by_____

NAME_____

ADDRESS_____

CITY_____ STATE____ ZIP CODE_____

AGE_____ DATE OF BIRTH_____

SEX_____ HEIGHT_____ WEIGHT_____

MARRIED_____ SINGLE_____

PARTNER'S FIRST NAME_____

OCCUPATION_____

HOME PHONE_____ WORK PHONE_____

EMAIL ADDRESS_____

Please list below in order of importance your five (5) or more main complaints or concerns:

1._____

2._____

3._____

4._____

5._____

6._____

PAST HISTORY

YES	NO	HAVE YOU EVER HAD	FOR HEALTH CENTER
		Diabetes	
		High Blood Pressure	
		Heart murmur	
		Heart attack	
		High cholesterol	
		Seizures	
		Stroke	
		Asthma	
		Emphysema	
		Hay Fever/Sinus	
		Pneumonia	
		Ulcers	
		Hepatitis	
		Thyroid problem	
		Arthritis	
		Anemia	
		Venereal Disease	
		Urinary infection	
		Cancer	
		Breast lump	
		Abnormal PAP smear	
		Drug abuse	
		Depression	
		Psychotherapy	
		Uterine infection	
		Kidney Disease	
		Tuberculosis	
		Varicose-veins	

OTHER MAJOR ILLNESS OR INJURY

(conditions which lasted for more than a few days or which prevented work or usual activities for several days)

YEAR	What illness/injury?

DRUG ALLERGIES OR SEVERE REACTIONS

NONE ☐

DRUG	YEAR	WHAT HAPPENED?

DRUGS CURRENTLY TAKEN

(Once/month or more)

NONE ☐

DRUG	HOW OFTEN?	WHAT FOR?

STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS (Check one or more)

	Buy medication on my own to treat myself
	Never take medications unless prescribed
	Usually want a medication prescribed for my illness
	Willing to try non-drug treatments
	Strongly prefer non-drug treatments
	Never take drugs or only as last resort

SURGERIES AND HOSPITALIZATIONS

(Do not include emergency room visits or childbirth)

YEAR	WHY HOSPITALIZED/WHAT SURGERY?

MENSTRUAL HISTORY

Age periods began: _____ age

Spacing of periods:
(Number of days from 1st day of one to 1st day of next) _____ days

Duration: (Number of days of bleeding) _____ days

Amount of flow: _____ light
_____ moderate
_____ heavy

Severe menstrual cramps: _____ yes
_____ no

Age periods stopped: _____ age

SMOKING HISTORY

□ Smoking cigarettes currently
_____ Packs per day
_____ Year started

□ Stopped smoking cigarettes
_____ Year started
_____ Year stopped
_____ Packs per day when smoked

□ Smoke pipe or cigars now □ in the past

□ Smoke marijuana now □ in the past

□ Smoker in the household

BIRTH CONTROL

□ Presently having sexual intercourse

□ Currently use birth control
Which method? _____
Previous methods: _____
_____

□ Do not use birth control

ALCOHOL USE

□ Do not use alcohol currently

□ Currently drink (even if only occasionally)

How often: □ Less than 1 drink/month
□ 1—3 drinks/month
□ 1—3 drinks/week
□ 1—3 drinks/day

How many drinks do you have at one time? *
□ 1 or 2 drinks
□ 3 or 4 drinks
□ 5 or more drinks

* One "drink" = one beer, one glass of wine or one shot of liquor

OBSTETRICAL HISTORY

Number of times pregnant: _____
Number of full-term babies: _____
Number of premature babies: _____
Number of abortions/miscarriages: _____
Number of living children: _____
Number of still-born babies: _____

HEALTH RELATED HABITS

Average number of hours of sleep per night:
□ 6 or less □ 7 □ 8 □ 9 or more

Do you eat breakfast?
□ Rarely/sometimes □ Daily/almost daily

Do you eat between meals?
□ Rarely/sometimes □ Daily/almost daily

How much exercise do you get?
□ Often vigorous □ Often moderate
□ Sometimes □ Never

What is your current weight?
□ Underweight □ Normal
□ Slightly overweight □ Considerably overweight

Sexual relations satisfactory? Yes □ No □
Would you like to talk with someone about this? Yes □ No □

Do you drink coffee? Yes □ No □
Number of cups per day: _____

List any chemicals, dust fumes or hazards to which you are exposed in your present occupation: _____
_____

Your current life situation (both work and personal) is:
□ Mildly stressful □ Severely stressful
□ Moderately stressful

SYMPTOMS

(Please check if you have or have had any of the following symptoms)

SYMPTOM	NOW	PAST	OFTEN	SYMPTOM	NOW	PAST	OFTEN
Coughing blood				Constipation			
Chest pain when walking				Hemorrhoids			
Chest pain when breathing				Bowel habit change			
Leg pain when walking				Indigestion			
Breast lump				Excess belching			
Black stools				Excess gas			
Vomiting blood				Abdominal pain			
Jaundice (Yellow Skin)				Don't tolerate hot weather			
Trouble swallowing				Don't tolerate cold weather			
Trouble walking				Persistent hoarseness			
Fainting spells				Painful urination			
Passing out				Frequent urination			
Convulsions				Involuntary urination			
Tremors				Night urination			
Paralysis				Vaginal discharge			
Change in mole				Painful sexual relations			
Non-healing sore				Infertility			
Dizziness				Joint pains			
Headache				Backache			
Double vision				Nervousness			
Ear trouble				Excessive worry			
Nose trouble				Trouble sleeping			
Chronic cough				Trouble with memory			
Coughing phlegm				Trouble concentrating			
Swollen ankles				Depression			
Abnormal bleeding				Crying spells			
Frequent bloody nose				Feelings of worthlessness			
Shortness of breath				Nightmares			
Sneezing				Weakness			
Morning cough				Tiredness on awaking			
Night sweats				Numbness			
Nausea				Skin trouble			
Vomiting				Spotting			
Blood in stools				Spotting after sexual relations			
Diarrhea				Bleeding after menopause			
Swelling				Fluid retention			

HEALTH MONITORING

What was the year of your last:

Tetanus shot	_____	Breast exam by medical practitioner	_____	TB skin test	_____
Pap smear	_____	Mammogram	_____	Complete checkup	_____

FAMILY HISTORY

For each of the following conditions, check in the appropriate box or boxes if any of your blood relations have had that condition. CONDITION	None in Family	Spouse	Mother	Father	Children	Sisters	Brothers	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes											
High blood pressure											
Heart trouble											
Heart attack before 35											
High cholesterol											
Stroke											
Glaucoma											
Breast cancer											
Asthma											
Hay fever											
Tuberculosis											
Syphilis											
Gonorrhea											
HIV-positive											
Kidney disease											
Mental retardation											
Mental illness											
Suicide											
Alcoholism											
Drug abuse											
Other cancer (specify)											
Other genetic disease											
Living—current age											
Deceased—age at death											