ZERO MERIDIAN HEALTH

HOMEOPATHIC HISTORY FORM NEW PATIENT

Date: _____

Identification Data

Full legal name: _____

Age: _____ Date of birth: _____ Nationality _____

Weight: _____ Height: _____

Marital status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Married

Address: _____

City _____ State _____ Zip Code _____

Home Phone Number: _____ Celllular: _____

E-mail: _____ Occupation: _____

School currently attending: _____ School Level _____

Who do you live with? _____

Do you have pets? ☐ Si ☐ No

Name of primary care physician (PCP) _____

PCP Phone Number _____

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PLEASE, READ BEFORE FILLING THIS FORM

Homeopathy is a comprehensive, non-invasive and individualized healing system that provides relief for physical, emotional and mental conditions.

Homeopathy is an alternative healing art practice and its practice without license in the state of California is contemplated in the Business and Professions Code, sections 2053.5 and 2053.6

Homeopathic treatment considers the integral health status of each person and addresses each particular condition with a homeopathic remedy adapted to that individual and circumstance.

Homeopathic remedies are regulated under the Federal Food, Drug and Cosmetic Act. Currently there are no FDA approved homeopathic products. They are available over the counter (OTC). Homeopathic products are subject to the same requirements related to approval, adulteration and incorrect labeling as other pharmaceutical products.

To evaluate your particular situation, it is important that you answer the following questions. Your cooperation is essential to the process of choosing the appropriate homeopathic remedy.

Your information will be absolutely confidential, and may not be revealed to anyone without written permission, except where disclosure is required by law.
Example:

1. A reasonable suspicion of child or elder abuse

2. A reasonable suspicion that a client presents a danger to him or herself or to others

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PART 1- INFORMATION ABOUT YOUR CONDITION

Describe your main complaint including the approximate date of onset of the condition, factors related to initiation, course, studies conducted and treatments performed.

Are there any factors that make your complaint worse or act as a trigger for exacerbations?

Describe:

Are there any factors that improve your complaint?

Describe:

Does your main complaint correspond to any conventional medical diagnosis?

Describe:

Describe any other complaints or additional medical conditions (physical, mental, or emotional)

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HISTORY OF PAST ILLNESSES

Below is a list that includes relevant ailments. Mark the ones that affect you

PSYCHIATRY

- ☐ Abuse
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder (anorexia nervosa, bulimia, body dysmorphic disorder)
- ☐ Grief
- ☐ Impulse control disorder
- ☐ Obsessive-compulsive disorder
- ☐ Panic disorders
- ☐ Postpartum depression
- ☐ Posttraumatic stress disorder (shock)
- ☐ Psychosis/Schizophrenia
- ☐ Substance use (alcohol, amphetamines, cocaine, opiates, etc.)
- ☐ Suicidal ideation

SKIN

- ☐ Acne
- ☐ Bacterial infections (carbuncles, cellulitis, erysipelas, folliculitis, furuncles, impetigo)
- ☐ Boils
- ☐ Bullous and blistering diseases (Pemphigus, Porphyria)
- ☐ Drug eruptions/hypersensitivity (urticaria, rashes, erythema)
- ☐ Eczema
- ☐ Fungal infections (tinea, onychomycosis)

- ☐ Itching eruption
- ☐ Melanoma
- ☐ Pediculosis
- ☐ Psoriasis
- ☐ Ringworms
- ☐ Rosacea
- ☐ Scabies
- ☐ Seborrheic keratosis
- ☐ Skin discoloration
- ☐ Viral infections (herpes simplex, Herpes Zoster/varicella)

PULMONARY

- ☐ Asthma
- ☐ Bronchiolitis
- ☐ Chronic cough/ chronic bronchitis
- ☐ Chronic obstructive pulmonary disease /Emphysema
- ☐ Difficulty breathing
- ☐ Pneumonia
- ☐ Pulmonary hypertension
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Tuberculosis

CARDIOLOGY

- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Congestive heart failure

- ☐ Hypertension
- ☐ Hypotension
- ☐ Hyperlipidemia
- ☐ Ischemic heart disease
- ☐ Mitral valve prolapse
- ☐ Pericarditis
- ☐ Peripheral arterial disease
- ☐ Syncope

ENDOCRINOLOGY

- ☐ Adrenal insufficiency
- ☐ Amenorrhea
- ☐ Cushing syndrome
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypogonadism

RHEUMATOLOGY

- ☐ Back pain
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Lumbago
- ☐ Lupus
- ☐ Osteoporosis

- ☐ Sjogren's syndrome
- ☐ Scleroderma
- ☐ Polymyositis
- ☐ Polymyalgia rheumatica
- ☐ Rheumatoid arthritis

HEMATOLOGY

- ☐ Anemia
- ☐ Bleeding/Coagulation disorder

GASTROENTEROLOGY

- ☐ Ascites
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Diverticular disease
- ☐ Epigastric pain
- ☐ Food poisoning
- ☐ Gastroesophageal reflux disease
- Inflammatory bowel disease
- ☐ Irritable colon
- ☐ Liver disease
- ☐ Malabsorption
- ☐ Ulcers (stomach/duodenal)
- ☐ Worms

ALLERGY AND IMMUNOLOGY

- ☐ Anaphylaxis

- ☐ Angioedema
- ☐ Allergic rhinitis

NEUROLOGY

- ☐ Cramps
- ☐ Convulsions
- ☐ Dementia
- ☐ Dizziness
- ☐ Faintness
- ☐ Headaches
- ☐ Head trauma
- ☐ Multiple sclerosis
- ☐ Muscle numbness
- ☐ Myasthenia gravis
- ☐ Paralysis
- ☐ Parkinson's disease
- ☐ Restless leg syndrome
- ☐ Stroke
- ☐ Tremors/Jerking/Twitches
- ☐ Vertigo
- ☐ Weakness

NEPHROLOGY/UROLOGY

- ☐ Enlarged prostate
- ☐ Impotence
- ☐ Incontinence
- ☐ Renal failure

- ☐ Renal hypertension
- ☐ Urinary Tract Infection (cystitis, pyelonephritis, prostatitis)

INFECTIOUS DISEASES

- ☐ Candida
- ☐ Chicken-pox
- ☐ Cytomegalovirus
- ☐ Fungal infections- skin or nails- (Tinea, Candida, etc.)
- ☐ Hepatitis A, Hepatitis B, Hepatitis C
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Infective endocarditis
- ☐ Influenza A, Influenza B
- ☐ Measles
- ☐ Mumps
- ☐ Osteomyelitis
- ☐ Otitis Externa
- ☐ Otitis Media
- ☐ Pharyngitis
- ☐ Rubella
- ☐ Scarlatina
- ☐ Sepsis
- ☐ Sexual Transmitted Diseases (urethritis, cervicitis, pelvic inflammatory disease, human papillomavirus, syphilis, warts)
- ☐ Sinusitis
- ☐ Skin infection (Impetigo, erysipelas, cellulitis, folliculitis, furuncles, carbuncles, boils)

- ☐ Soft tissue infection
- ☐ Vector-borne disease (Lyme, Malaria)
- ☐ Tonsillitis
- ☐ Ulcerative Genital Diseases (chancroid, herpes simplex type 2)
- ☐ Varicella-Zoster
- ☐ Whooping cough

GYNECOLOGY/ OBSTETRICS

- ☐ Abortion
- ☐ Amenorrhea
- ☐ Infertility
- ☐ Leiomyoma
- ☐ Menopause
- ☐ Miscarriage
- ☐ Nausea and vomiting during pregnancy
- ☐ Premenstrual Syndrome
- ☐ Vaginal infection

ONCOLOGY

- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Ovarian cancer
- ☐ Prostate cancer
- ☐ Pulmonary cancer
- ☐ Thyroid cancer
- ☐ Testicular cancer

☐ Other

☐ End of life stage

ANY SURGERY

☐ Appendix

☐ Cataract

☐ Gallbladder stones

☐ Heart Bypass / Stent

☐ Hernia

☐ Other

☐ Any history of accident or injury - **Describe**

☐ Any occasion of unconsciousness - **Describe**

List any conventional medicine and Alternative therapies taken (herbs, vitamins, supplements, Acupuncture).

List any allergies or sensitivities to medications or any other substances:

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Describe your family history of past illnesses.

Relationship	Alive-Age	Diseases	Dead	Cause of death
Paternal grandfather				
Paternal grandmother				
Maternal grandfather				
Maternal grandmother				
Father				
Mother				

Sibling information- Indicate your position by writing "Self"

#	Brother / Sister	Age- Alive / Dead	Disease suffered
1			
2			
3			
4			
5			

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Do any of your relatives have the same condition as you?

PART 2: Information about You

Personal History

Birth History

Did your mother have any illness, accident, emotional conflict, medical treatment or any problem during the pregnancy? **Describe**

Was there any difficulty during your birth?

Milestones

Event	Age
Smiling	
Teething	
Sitting	
Eating finger food	
Walking	
Speaking	
Bedwetting control	

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VACCINATION

☐ BCG

☐ Hepatitis B

☐ DTaP (diphtheria, tetanus and pertussis-whooping cough)

☐ Haemophilus influenzae type B disease (Hib)

☐ Polio (IPV)

☐ Pneumococcal disease

☐ Rotavirus

☐ Influenza (flu)

☐ Chicken-pox

☐ MMR (measles, mumps and rubella)

☐ Varicella

☐ HPV

☐ Meningococcal disease

☐ Other

Was there a reaction or problem after a vaccine? **Describe**

Habit	How Much
Alcohol	
Smoking	
Chapstick	
Coffee	
Vicks VapoRub or any other menthol topical ointment	
Sleeping pills	
Recreational drugs	

FEEDING HABITS

How is your appetite?

Is there any change in your appetite?

How often do you eat?

What do you like to eat and what do you not like?

Do you feel hungry after eating?

Is there any change in your sense of taste?

How thirsty are you?

What do you like to drink?

BOWEL MOVEMENTS

How often do you evacuate?

Do you experience urgency or fecal incontinence?

Do you have to strain to defecate? Do you experience tenesmus?

Do you pass gas excessively?

URINATION

How often do you urinate?

Is there any unusual odor?

Is there a problem with the flow of urine (difficulty starting, interrupted, dripping)

Do you get up at night to urinate?

Do you urinate more during the night?

Do you suffer from urinary incontinence?

BODY TEMPERATURE AND PERSPIRATION

Is there any cold or heat sensation in any part of your body?

Do you use thermal bags for cold extremities?

How much do you sweat?

What part of your body sweats?

Describe your sweating (sticky, cold, warm, greasy)

Does your sweat produce odor? Describe

Does your perspiration stain your clothes? What color?

Do you sweat in bed?

STATE OF MIND AND EMOTIONAL STATE

Do you remember any crucial moment or shocking situation in your life? Describe

Do you experience a loss of interest or pleasure in the things you generally enjoy?

Do you experience thoughts of guilt or worthlessness?

Do you have trouble concentrating?

Do you experience thoughts about death or suicide?

Are you worried or concerned about any situation?

Do you experience any panic attacks?

Do you experience any phobia?

Do you have fears? -Describe

Are you doubtful or suspicious of anything or anyone?

Do you hear voices in your mind?

What activities do you enjoy?

What do you dislike?

SLEEP AND DREAMS

Do you suffer from insomnia?

Do you have trouble falling asleep?

How many hours do you sleep on average?

Do you have interruptions during sleep?

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When sleeping:

Do you snore?

Do you grind your teeth?

Do you walk?

Do you speak?

Do you dream? -Describe

Do you have recurring dreams? -Describe

FACTORS THAT MAY AFFECT YOU AND YOUR HEALTH

Indicate if any of the following factors affect you and specify how.

	Better	Worse
Day/Light		
Night/Darkness		
Silent environment		
Music		
When alone		
In company		
When occupied		
Hot weather		
Cold weather		
Rainy weather		
Cloudy weather		
Change of seasons		
Fasting		
After eating		
After sleeping		
Being outdoor		
Near ocean		
Near mountain /Hiking		
In a closed room		
In a crowd		

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	Better	Worse
Warm bath		
Cold bath		
After walking		
Near pets		
Strong odors		
Orderly / Clean surrounding		
After weeping		
To be comforted when feeling sad		