Date:

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| Name: | |  | | | | | | | | |
| Date of birth: | |  | | | Age: |  | | Sex: |  | |
| Address: | |  | | | | | | | | |
| Phone number:  Mobile number:  (include international prefix if applicable)  **Skype address:**  (If consult online) | |  | | | | | | | | |
| Email: | |  | | | | | | | | |
| **Person filling out form:** Name and relationship to patient (same/Mother/Father/guardian/friend/carer, etc). | | | | | | | | | | |
|  | | | | | | | | | | |
| HOW TO FILL OUT THIS FORM   1. Read all instructions 2. Add your answers. Fill in only what you feel comfortable filling in and leave the rest blank. Please pay special attention to filling in the information regarding what makes it better or what makes it worse. 3. Save this document with a new file name that includes your name,  e.g., Jane Smith proforma May 18 2021.doc 4. Save as a Word document ( .doc or .docx) 5. Do not send as .pages 6. Email the form to [louisattardhomeopathy@gmail.com](mailto:louisattardhomeopathy@gmail.com)   \*Homeopathy is a unique system of medicine that looks at the body as a whole. The more information you can provide regarding different, seemling unconnected issues, the easier it will be to select the correct homeopathic remedy for you. Also, often a diagnosed condition will have a range typical symptoms, yet you may not experience all of those symptoms (and may even experience some additional symptoms) and so describing the specific symptoms you experience will be more helpful to finding the correct remedy for your body. | | | | | | | | | | |
| SECTION 1 - MAIN COMPLAINT & OTHER MAJOR COMPLAINTS | | | | | | | | | | |
| Describe your main complaint/s in as much detail as you can in the following 3 areas. | | | | | | | | | | |
| **1. General description of complaint/s:** | | | | | | | | | | |
|  | | | | | | | | | | |
| **2. Onset:**  The date and corresponding factors, including any stress at the same time as the complaint commenced, or anywhere up to two years earlier than the first sign of the complaint. | | | | | | | | | | |
|  | | | | | | | | | | |
| **3. How the problem presents on a day-to-day basis:**  Include what modifies\* the complaint  \* = factors that may change the presentation of the complaint – either making it feel worse or better (even if for a short time) – examples include food, drink, weather, time, indoors/outdoors, temperature, heat/cold – applications or weather, rain, wind, storms, pressure, touch, movement, sitting, lying (on side?), vomiting, sweating, fasting, passing stool, urinating, periods (before, during, after), time of year, moon phases, sleep (during, after, better for, worse for), waking, exercise, exertion, emotional interaction (weeping, company, being alone, mood changes, etc) – anything that is noticeable and has been seen as a repeating pattern. This does not include use of drugs. | | | | | | | | | | |
|  | | | | | | | | | | |
| Other complaints  **Describe in the same way as for your main complaint, including all information about modifying factors. Add additional rows for multiple complaints.** | | | | | | | | | | |
| 1. General description of complaint/s: | | | | | | | | | | |
| 2. Onset: | | | | | | | | | | |
| 3. How the problem presents on a day-to-day basis: | | | | | | | | | | |
| **Current treatment:**  Name any drugs currently taken (prescription or recreational) and other treatments tried for this complaint – *brief description only.* | | | | | | | | | | |
|  | | | | | | | | | | |
| SECTION 2 – PHYSICAL OVERVIEW | | | | | | | | | | |
| **Give details for any of the following problems that apply. Include information about modifying factors as above.**  If the physical problem has ceased please include when it occurred and what made it improve – e.g., change of diet, change of habits, change of living arrangement, just went, drugs, operation, etc.  Note – describe all discharges, including colour and texture – e.g., clear, yellow, green, bloody, thick, thin, runny, gluey. | | | | | | | | | | |
| **Hair**(falling out, very dry, very oily, rapid change of colour, etc) | | | | | | | | | | |
| **Scalp**(eruptions, itchy, etc) | | | | | | | | | | |
| **Headaches**(patterns and modifying factors) | | | | | | | | | | |
| **Eyes** (allergies, watery, itching, sties, inflammation, discharges) | | | | | | | | | | |
| **Vision** (spots, colours, flashes, short/long-sighted, etc) | | | | | | | | | | |
| **Ears** (inflammation, discharges, pain, eruptions) | | | | | | | | | | |
| **Hearing** (loss of, noises (include what the noise sounds like)) | | | | | | | | | | |
| **Nose** (obstructed, running, discharge, side, growths, blood noses, etc) | | | | | | | | | | |
| **Mouth** (ulcers, cold sores, eruptions, salivation, dryness, taste (sweet, sour, salty, putrid, metallic, etc)) | | | | | | | | | | |
| **Tongue**(unusual colour, cracks, marks) | | | | | | | | | | |
| **Teeth** (excessive decay, breaking/crumbling, abscesses, discolouration, pain) | | | | | | | | | | |
| **Braces**(what was wrong with teeth before braces: crooked, overbite, front two protruding, gaps, etc – Thisis important for the facial analysis – if you have a photo of the teeth before the braces please include) | | | | | | | | | | |
| **Throat** (sore, inflammation, tonsillitis, itchy, dry, discharge, etc) | | | | | | | | | | |
| **Larynx**(loss of voice) | | | | | | | | | | |
| **Speech**(stuttering, loud voice, quiet voice, can’t remember words, switches words or letters, etc) | | | | | | | | | | |
| **Breathing** (difficult, ascending, descending, on exertion, asthmatic – type, etc) | | | | | | | | | | |
| **Lungs** (inflammation, bronchitis, pneumonia, pleurisy, congestion, coughing, etc) | | | | | | | | | | |
| **Stomach** (pains, relationship to eating/drinking, etc) | | | | | | | | | | |
| **Digestion** (heartburn, pain, reflux, bloating, distension, flatulence, burping) | | | | | | | | | | |
| **Appetite** ( food cravings, food dislikes, food that makes you sick – consider the following groups and please mark the box with an x for each category of food and your response to it) | | | | | | | | | | |
| **Food group** | **Crave** | | **Like** | **Indifferent** | | | **Hate taste** | | **Makes me sick or allergic to** |
| Sweet |  | |  |  | | |  | |  |
| Chocolate |  | |  |  | | |  | |  |
| Salty |  | |  |  | | |  | |  |
| Sour |  | |  |  | | |  | |  |
| Bitter |  | |  |  | | |  | |  |
| Fruit |  | |  |  | | |  | |  |
| Vegetable |  | |  |  | | |  | |  |
| Salad |  | |  |  | | |  | |  |
| Meat – steak |  | |  |  | | |  | |  |
| Meat – chicken |  | |  |  | | |  | |  |
| Meat - pork |  | |  |  | | |  | |  |
| Fish |  | |  |  | | |  | |  |
| Eggs |  | |  |  | | |  | |  |
| Cheese |  | |  |  | | |  | |  |
| Yoghurt |  | |  |  | | |  | |  |
| Butter |  | |  |  | | |  | |  |
| Cream |  | |  |  | | |  | |  |
| Oily/fatty/fried |  | |  |  | | |  | |  |
| Bread |  | |  |  | | |  | |  |
| Cakes/pastry |  | |  |  | | |  | |  |
| Spicy |  | |  |  | | |  | |  |
| Herbs |  | |  |  | | |  | |  |
| Hot food |  | |  |  | | |  | |  |
| Cold food |  | |  |  | | |  | |  |
| **Drinks** | **Crave** | | **Like** | **Indifferent** | | | **Hate taste** | | **Makes me sick or allergic to** |
| Coffee |  | |  |  | | |  | |  |
| Tea |  | |  |  | | |  | |  |
| Water |  | |  |  | | |  | |  |
| Fruit juice |  | |  |  | | |  | |  |
| Iced drinks |  | |  |  | | |  | |  |
| Soft drinks |  | |  |  | | |  | |  |
| Milk |  | |  |  | | |  | |  |
| Wine |  | |  |  | | |  | |  |
| Beer |  | |  |  | | |  | |  |
| Spirits |  | |  |  | | |  | |  |
| **Any other food interactions that you feel are important – please add here:** | | | | | | | | | | |
| **Bowels** (constipation, diarrhoea, loose stools, colour, shape, odour (where distinctive), blood, undigested, pain, haemorrhoids, frequency, urgency) | | | | | | | | | | |
| **Urination** (pain, frequency, profuse, scanty, blood) | | | | | | | | | | |
| **Periods** (age of onset, current pain or history of pain – where and description, irregular, heavy, clots, associated problems, PMT (how does this exhibit), better or worse for flow of blood, colour of blood) | | | | | | | | | | |
| **Female** (libido issues, discharge, warts, cysts, fibroids) | | | | | | | | | | |
| **Pregnancy** (how many, problems, sterility, abortions, miscarriages – time etc) | | | | | | | | | | |
| **Male** (libido issues, prostate) | | | | | | | | | | |
| **Limbs** (pain, cramps, joint problems, numbness, tingling) | | | | | | | | | | |
| **Back**(pain, sciatica, numbness, tingling) | | | | | | | | | | |
| **Hands/feet** (cold, hot, sweat, odour) | | | | | | | | | | |
| **Skin**(dry, oily, eruptions - where, warts, moles, cracks) | | | | | | | | | | |
| **Nails** (unusual colour, thickness, breaking etc) | | | | | | | | | | |
| SECTION 3–GENERAL CONDITIONS | | | | | | | | | | |
| **Sleep** (general description of sleep – including difficulty in getting to sleep, frequent waking, times of waking if there is a pattern, favourite sleep position, hot/cold in bed, sweating, restless, waking unrefreshed, talking in sleep, etc) | | | | | | | | | | |
| **Dreams** (briefly describe the types of dreams you have – vivid, happy, frightening, nightmares, repeating dreams, repeating themes, a dream when young that still remains as a strong memory) | | | | | | | | | | |
| **Relationship with weather/seasons**(love/hate: winter, summer, autumn, spring, hot, cold, windy, rainy, thunder/lightning, direct sun, dry, humid) | | | | | | | | | | |
| **Body thermals** (chilly, hot, changeable) | | | | | | | | | | |
| **Perspiration**(never, slight, profuse, hot, cold, when, where) | | | | | | | | | | |
| **Fears**(animals – snakes, spiders, dogs, etc; heights, strangers, robbers, death, closed spaces, exams, public speaking, driving, anything no matter how unusual. Give a description of how intense the fear is and what happens to you) | | | | | | | | | | |
| **Stress**(How do you behave when under stress? What are your less attractive behaviours? What complaint do others have about you?) | | | | | | | | | | |
| **Passions**(What are you most passionate about? Give a brief description of you and your passion.) | | | | | | | | | | |
| SECTION 4–PREVIOUS REMEDIES GIVEN | | | | | | | | | | |
| **Please mention names of previous remedies given (with potency where known) and which ones had a POSITIVE result.** | | | | | | | | | | |
| SECTION 5–BACKGROUND INFORMATION | | | | | | | | | | |
| **Life patterns:**  Describe your life in terms of which events/situations were the *most traumatic, stressful or made a definite impression upon you*. Put them in chronological order from childhood to now.  **This information to be listed in summary dot points – basic information only – we can discuss important events in more detail during your consultation if they are significant to your health.** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Family history:**  Include main illness or weakness – ifcurrently alive, or illness at death and age of death. | | | | | | | | | | |
| * **Mother:** * **Father:** * **Maternal Grandmother:** * **Maternal Grandfather:** * **Paternal Grandmother:** * **Paternal Grandfather:** | | | | | | | | | | |
| **For children only**  **Parent or carer –only fill out this information if the patient is your child.** | | | | | | | | | | |
| * **Conception details:** (any stressful events at that time) * **Pregnancy:** * **Labour:**(anything unusual) * **Infancy:** (feeding, sleeping, illnesses – notalready mentioned in physical overview, reactions to vaccines) * **Development:**(normal, late or early:sitting, crawling, walking, talking, teething – describein detail if out of normal range) | | | | | | | | | | |
| SECTION 6–CHILDREN: CHARACTER | | | | | | | | | | |
| **How does your child behave when stressed** – fights, loud, quiet, shy, timid, hides, hits, throws, jealousy, remorse, etc  **Interaction with friends, family (especially siblings) and at school**  **Passions**  **Unusual or distinguishing behaviours** | | | | | | | | | | |
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