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Full Chronic Consultation Questionnaire (10 pages)

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of birth: _____ Age: _____ Male/Female: _____

Height: _____ Weight: _____

Relationship status: Single Married Divorced Widowed In A Relationship

Major Complaints in order of importance to you:

Complaint	How long ago	Describe related symptoms (How often do they occur? How long do they last?)	Rate (1-10)

Please be open and honest when answering all questions. Everything is held in the utmost confidence and without judgement as it is needed to make a complete assessment of your totality of symptoms. The littlest thing may be the very layer blocking your body from finding balance and being able to self-heal. With that being said, please only fill out what you feel comfortable with.

Were you born via natural birth or C-section? Please describe any traumas or difficulties during birth.

_____

Please list any newborn, infant, toddler, and/or childhood health issues/illnesses.

_____

_____

Please list any medications (OTC and Rx) (from birth to present) and any reactions:

Medication	When	Reaction

What vaccinations have you had and when (from birth to present) and any reactions:

Vaccination	When	Reaction

Please list any supplements (vitamins, minerals, herbs, etc.) (from birth to present) and any reactions:

Supplement	When	Reaction

Please list any allergies or intolerances (e.g. food, smoke, bees, metal, antibiotics, etc.):

_____

Are your bowel movements regular? If no, please describe: _____

What color is your urine? Circle one: clear pale medium yellow bright yellow dark

Perspiration (circle all that apply): profuse scanty average strong odor little/no odor stain clothing
If profuse, describe where on the body and when it happens: _____

Describe your sleep (restful, restless, specific or recurring dreams, etc.):

_____

What is your preferred sleep position? _____

What are your energy levels? When are they best? When are they worse?

_____

Do you exercise? If yes, please describe: _____

Describe your mental state (optimistic, pessimistic, happy, depressed, sad, worried, anxious, fears, etc.; How do you handle stress? Do you get offended easily? How do you handle criticism? Are you easily startled?):

_____

_____

Describe your relationships with your spouse, children, parents, coworkers, friends, family, etc.:

_____

_____

Indicate your use of the following:

	Per day	Per week	Per month
Coffee/Caffeine			
Candy/Sugar			
Tobacco			
Alcohol			
Recreational drugs			

Please check if you have any family history of:

☐ Alcoholism	☐ Digestive disorders	☐ Mental illness
☐ Allergies	☐ Epilepsy	☐ Paralysis
☐ Alzheimer's	☐ Gonorrhea	☐ Pneumonia
☐ Asthma	☐ Gout	☐ Polio
☐ Arthritis	☐ Hay fever	☐ Psoriasis
☐ Cancer	☐ Heart disease	☐ Skin disease
☐ Dementia	☐ Hepatitis	☐ Syphilis
☐ Depression	☐ Hypertension	☐ Thyroid disorder
☐ Diabetes	☐ Kidney disease	☐ Tuberculosis
☐ Other:		

Please check if you have ever had any of the following conditions:

☐ Abscesses	☐ Gallstones	☐ Mononucleosis
☐ Adrenal disorder	☐ Gonorrhea	☐ Mumps
☐ Alcoholism	☐ Gout	☐ MRSA
☐ Anemia	☐ Hepatitis	☐ Paralysis
☐ Anxiety	☐ Herpes	☐ Polio
☐ Appendicitis	☐ Influenza	☐ PTSD
☐ Arthritis	☐ Jaundice	☐ Rheumatic fever
☐ Autoimmune disease	☐ Kidney disease	☐ Scarlet fever
☐ Cancer	☐ Leukemia	☐ Stroke
☐ Chicken pox	☐ Liver disease	☐ Syphilis
☐ Covid	☐ Lyme	☐ Thyroid disorder
☐ Depression	☐ Malaria	☐ Tuberculosis
☐ Diabetes	☐ Measles	☐ Whooping cough
☐ Epstein-Barr	☐ Mental illness	☐ Other:

Please list any conventional medical diagnoses:

_____

_____

_____

_____

Place a check mark for current symptoms. Put a 'P' if you have suffered in the past.

Skin:

___ rashes	___ eczema	___ hives	___ acne
___ boils	___ itching	___ lumps	___ dry hair
___ dryness	___ scaling	___ psoriasis	___ moles
___ warts	___ cracked skin	___ fungal infections	___ pigmentations
___ birth marks	___ falling/thinning hair	___ nail changes	___ peeling nails
___ splitting nails	___ cracked nails	___ ridged nails	___ white spots on nails
___ nail fungus	___ other:		

Head:

___ headache	___ dizziness	___ vertigo	___ tinnitus
___ migraines	___ head injuries	___ other:	

Ears:

___ earache	___ infections	___ redness	___ discharge
___ ringing	___ buzzing	___ impaired hearing	___ other:

Eyes:

___ eye pain	___ tearing	___ dryness	___ itching
___ redness	___ blurring	___ discharge	___ floaters
___ flashes	___ sparks	___ impaired vision	___ double vision
___ glaucoma	___ cataracts	___ other:	

Nose/sinuses:

___ frequent colds	___ stuffiness	___ runny	___ hay fever/allergies
___ nose bleeds	___ obstruction/blockage	___ nasal discharge	___ loss of smell
___ facial pain	___ other:		

Mouth and throat:

___ sore throats	___ strep throat	___ canker sores	___ cold sores
___ dry lips	___ bleeding gums	___ receding gums	___ loss of taste
___ dental cavities	___ bad breath	___ dry mouth	___ tonsillitis
___ tonsil stones	___ other:		

Neck:

___ lumps	___ goiter	___ swollen glands	___ pain or stiffness
___ difficulty swallowing	___ other:		

Respiratory:

___ cough	___ sputum	___ spitting blood	___ wheezing
___ asthma	___ bronchitis	___ pneumonia	___ emphysema
___ difficulty breathing	___ shortness of breath	___ allergies	___ other:

Cardiovascular:

___ palpitations	___ chest pain on exertion	___ blueness of lips	___ swelling of ankles
___ high blood pressure	___ low blood pressure	___ irregular pulse	___ other:

Gastrointestinal:

___ heartburn	___ nausea	___ vomiting	___ constipation
___ diarrhea	___ gas	___ belching	___ bloating
___ abdominal pain	___ lack of appetite	___ ineffectual urging	___ hemorrhoids
___ indigestion	___ food allergies	___ food intolerances	___ parasites/worms
___ other:			

Musculoskeletal:

___ pain in joints	___ swollen joints	___ stiffness in joints	___ broken bones
___ muscle spasms	___ muscle cramps	___ muscle twitching	___ other:

Peripheral vascular:

___ deep leg pain	___ cold hands	___ cold feet	___ varicose veins
___ ulcers	___ extremity numbness	___ extremity coldness	___ extremity swelling
___ other:			

Neurological:

___ fainting	___ convulsions	___ paralysis	___ tremors
___ numbness	___ tingling	___ weakness	___ involuntary movements
___ loss of memory	___ difficulty concentrating	___ loss of balance	___ speech problems
___ epilepsy	___ seizures	___ difficulty in initiating movements	
___ other:			

Endocrine:

___ cold intolerance	___ excess thirst	___ excess hunger	___ sudden weight gain
___ sudden weight loss	___ heat intolerance	___ excess sweating	___ other:

Reproductive system - MALE:

___ testicular pain	___ testicular masses	___ abnormal penile discharge
___ sexual difficulties	___ erectile difficulties	___ fertility difficulties
___ enlarged prostate	___ pain during intercourse	___ premature ejaculation
___ prostate disease	___ urinary tract infection	___ yeast infection
___ incontinence	___ STDs:	___ other

Reproductive system - FEMALE:

Age of first menses: _____ Date of last menses: _____

Length of cycle: _____ Length of menses: _____

# of pregnancies:	# of children:	Pre-menopause/Menopause/Post-menopause (naturally or medically induced?)	Hysterectomy? (full or partial)

Miscarriages? If yes, how many?	Abortions? If yes, how many?	Contraceptives? If yes, what?
___ irregular cycle	___ pain during cycle	___ pain between cycles
___ PMS	___ acne before/during menses	___ hot flashes
___ mood swings	___ bloating	___ swollen breasts
___ painful/tender breasts	___ craving	___ heavy bleeding
___ light bleeding	___ bleeding, stringy	___ bleeding w/clots
___ bright red bleeding	___ dark red bleeding	___ pink discharge between cycles
___ thick discharge between cycles	___ smelly discharge	___ dryness
___ cysts	___ endometriosis	___ fibroids
___ pain during intercourse	___ dryness during intercourse	___ bleeding during intercourse
___ pelvic inflammatory disease	___ yeast infection	___ urinary tract infection
___ difficulties conceiving	___ difficulties carrying to term	___ incontinence
___ hormone replacement therapy	___ STDs:	___ other:

Please describe your childhood:

_____

_____

Please describe what makes you the happiest and/or where/when you are the happiest:

_____

_____

What is your job/occupation/profession? Explain why you chose it. Are you satisfied?

_____

Please list your favorite food(s) and why. Please describe when you feel hungry:

_____

_____

_____

When was your last high fever (above 101.3)? Describe the symptoms:

_____

How often do you experience a common cold? Does it resolve on its own or go into secondary infections?

_____

Have you had COVID-19? If yes, what symptoms resulted from the infection? Are there any lingering symptoms? Did any new symptoms arise after the infection that you feel were caused by the infection?

_____

_____

_____

How would you describe your personality?

_____

When you were a kid, what did you want to be when you grew up? _____

Why are you here today? What are your Goals? Desires? Wishes? Hopes? for this consultation.

_____

_____

_____

Major life events, traumas, and stress can have long-lasting effects on health as the body can hold on to these events without you realizing it. Please list surgeries, procedures, treatments, injuries, accidents, concussions, traumatic events, emotional events, major life changes, illnesses, hospitalizations, broken bones, sprains, strains, falls, changed schools, major events in school, graduated, failed, got married, had children, separated, divorced, custody fights, new job, lost job/fired, financial stress, any complications, bad memories, stressful events, physical abuse, emotional abuse, etc.
Nothing is too little or too ridiculous. If it's in your mind, it's potentially affecting your body.

Event	When	What effect on you/complications

I am 18 years of age or older and have voluntarily chosen homeopathy and/or natural wellness treatment for myself in order to increase my general vitality and constitutional strength. I understand that Angela Babb is not a medical doctor, and this is not medical advice. The information provided is for educational purposes and is intended solely as a sharing of knowledge and information. It is not intended to diagnose, treat, cure, mitigate, or prevent any symptom, disease, or condition nor replace a one-on-one relationship with a qualified health professional. I assume full responsibility for how I choose to use this information. I know that I am responsible for my own health and above all the lifestyle choices I make.

My signature below indicates that I have read and understood the Terms and Conditions (www.faithhomeopathy.com/terms-and-conditions), agree to abide by its terms, and hereby consent to homeopathic and natural wellness services.

_____

Print Client Name

_____

Client Signature (circle one) Self Parent Legal Guardian

_____

Date