HomeopathyMDForYou.com
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www.homeopathymdforyou.com

Online Homeopathic Consultation Questionnaire

Please answer the questions below in as much details as possible. This will help me make a better diagnosis of your medical condition(s) and prescribe the correct treatment.

After you have completed questionnaire please email it to info@homeopathymdforyou.com. Please allow 48 hours to respond. Once I review your questionnaire and determine that your medical condition(s) can be safely addressed via online consultation, I'll send you payment instructions. When your payment is received, I will send you detailed recommendations with all necessary information and treatment plans. If your condition(s) require further testing I'll let you know what tests I require???

Thank you for completing the questionnaire.

1. Personal Details

First Name						
MI						
Last Name						
Email						
Phone						
Address						
Country						
Date of Birth						
Gender	☐ Male	☐ Female	☐ Transgender			
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed		
No of Children						
Height		Weight		Physical Description		
Employed	☐ Full Time	☐ Part Time	☐ Retired	☐ Student		
Occupation						

2. Reason for Consultation

What is Your Reason for Consultation	

3. Current Symptoms

When did the symptoms begin?
What may the symptoms be related to?
Please describe any previous problems of this kind.
Please describe anything that you feel is associated with the current symptoms that is unusual, rare and peculiar or any other information that you wish to add
Please describe any important events in your life. How did you feel about them at the time? How do you feel about them now?

4. General Symptoms

Which weather makes you feel worse?			
At what time do you feel the worst?			
What do you feel when exposed to the sun? Wind? Snow?			
What do you feel about warmth in general? Warmth of the bed? Of the room?			
What body position do you like the best	☐ Sitting	☐ Standing	☐ Lying
How often do you catch a cold and when?			
Do you exercise?			
Do you get car sick?			
How do you feel before, during and after meals?			

What about your appetite, how do you feel if you go without a meal?
What do you drink and in what quantity? What about thirst?
Which foods do you prefer?
What are the foods that make you sick and why?
What about coffee / tea / milk / wine / beer / vinegar?
Do you smoke? How much a day?
Are there any drugs that you are very sensitive to or that make you sick?
What are the vaccinations you have had and the results from them?
How do you feel at the seaside or on high mountains?
How do collars, belts and tight clothing affect you?

5. Mental and Emotional Symptoms

On what occasions do you weep?	
At music?	
At Reproaches?	
At what time of day?	
Oter?	
How do you cope with your worries?	

What effect does comfort have on you?	
How do you stand waiting?	
Do you go red or white when you are angry and how do you feel afterwards?	
When and on what occasions do you feel anxious or frightened?	
How do you feel in a place full of people?	
How rapidly to you walk or eat or talk or write?	
Tell me anything unique or unusual about the following:	
Your memory?	
Your understanding?	
Your will?	
Your concentration?	
Tendency to make mistakes?	
At what time in the 24 hours do you feel	
Blues?	
Depressed?	
Sad?	
Pessimistic?	

6. Food and Sleep

List your meals through the day and their contents. List any likes, dislikes or allergies.					
What about pastry and sweets?					
What about sour or spiced food?					
What about reach or greasy food?					
What about thirst and what do you drink?					
How much salt do you need for your taste?					
Do you add salt to food at the table?					
Do you drink	☐ Coffee	☐ Tea	☐ Wine	☐ Beer	☐ Other
In which position do you sleep?					
When are you sleepy?					

What makes you restless or sleepy?	

7. For Women Only

At what age did your periods begin?	
How frequently do your periods come?	
Please describe their duration, abundance, color, and odor.	
Please describe any other significant details that may be relevant	
What about your character, feelings, or behavior before, during and after your period?	

8. Bodily Functions and Discharges

Any problems of the senses?	
Vision	
Smell	
Taste	
Do you have any problems in your mouth or dental problems?	
Do you have any skin problems like eczema, warts, tumors, psoriasis, or unexpected eruptions?	
Has a diagnosis been made for any condition? If so, by whom, what is it; detail of any advice given	
Are you taking any homeopathic medicine, conventional medication, herbs, vitamins or mineral supplements?	
Do you feel any pain?	
Is the pain you feel burning, aching, numbness and/or throbbing or other sensation? Provide any information	
Complete the sentence: “It feels as if…” about all your pains and discomforts:	

9. Your Personal History

Please detail your medical history since childhood as far as you can recall, including accidents, time in hospital, etc.

Please provide as much information as you can in regards with the medical history of your family and grandparents
Please describe your home circumstances and important relationships
What are your passions and leisure pursuits?
Are there important aspects of your life that have not been covered?

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