flora & fauna classical homeopathy
client questionnaire

Name: _____ Date of birth: _____

Address: _____

Phone: Home:_____ Work: _____

Cell: _____ Email:_____

Marital status: Single Married Partnered Widowed Divorced Separated

Number of children: _____ Height: _____ Weight: _____

Occupation: _____

Referred by:_____

Notice Regarding Homeopathic Services in California

I am aware that homeopathy may be practiced as an alternative healing art in California under sections 2053.5 and 2053.6 of the Business and Professions Code subject to these requirements and restrictions: 1) that the practitioner states s/he is not a licensed physician or health-care provider; 2) that homeopathic consulting services are not licensed by the state; 3) that homeopathic consulting is not represented as nor intended to be a substitute for conventional medical diagnosis or treatment and that it does not diagnose or treat specific pathological conditions or disease symptoms.

Acknowledgment

I understand homeopathy is a means of stimulating an individual's vital energy, using homeopathic remedies with the aim of increasing the general well-being of the whole person. I understand that homeopathic services are not medical treatment and that the homeopath is not a licensed physician. I will not hold Alexis White or flora & fauna classical homeopathy liable for my overall health or well-being.

If client is a minor, I acknowledge that all parents consent to homeopathic treatment for their minor child with Alexis White and flora & fauna classical homeopathy.

I have read the Office Policies for flora & fauna classical homeopathy.

Signature_____ Date _____

Major Complaints in order of importance to you:

1.

2.

3.

4.

Are you currently taking any medications or medicinal herbs? (use back of paper if needed)

What other treatments are you currently using?

Lifestyle

How much of the following substances do you consume:

- ❏ Tobacco:
- ❏ Alcohol:
- ❏ Coffee:
- ❏ Recreational drugs:

Food allergies?

What exercise do you prefer?

What types of weather do you especially like or dislike and why?

What things give you the most pleasure in life?

What things give you the most displeasure in life and why?

List any fears, worries or phobias you have:

Medical and Health History:

Check all that you have now, or you have had in the past:

- ❑ Abscesses
- ❑ ADD/ADHD
- ❑ Alcoholism
- ❑ Allergies
- ❑ Amnesia
- ❑ Anorexia/bulimia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bladder infection
- ❑ Bleeding problem
- ❑ Cancer
- ❑ Canker sores
- ❑ Changes in hair
- ❑ Chicken pox
- ❑ Chlamydia
- ❑ Chronic cold
- ❑ Chronic cough
- ❑ Cold sores
- ❑ Colic
- ❑ Concussion/head injury
- ❑ Constipation
- ❑ Depression
- ❑ Developmental delay
- ❑ Diabetes
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fibroids
- ❑ Gall stones
- ❑ Genital warts
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Hay fever
- ❑ Headaches
- ❑ Hearing problems
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood pressure
- ❑ Infertility
- ❑ Influenza
- ❑ Issues with sexual function
- ❑ Kidney disease
- ❑ Leukemia
- ❑ Liver disease
- ❑ Major tooth problems
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Menstrual cramps
- ❑ Menstrual irregularities
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Muscle cramps
- ❑ Neurological issues
- ❑ Panic attacks
- ❑ Parasites
- ❑ Pelvic inflammatory disease
- ❑ Peritonitis
- ❑ Persistent diarrhea
- ❑ Pleurisy
- ❑ PMS
- ❑ Pneumonia
- ❑ Prostatitis
- ❑ Rheumatic fever
- ❑ Rubella
- ❑ Scarlet fever
- ❑ Sensory Integration
- ❑ Sexual abuse
- ❑ Sexually transmitted disease
- ❑ Sinusitis
- ❑ Skin condition
- ❑ Strep throat
- ❑ Stroke
- ❑ Suicidal
- ❑ Syphilis
- ❑ Teething
- ❑ Thyroid condition
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcer
- ❑ Urinary problems
- ❑ Vertigo
- ❑ Vision problems (not glasses)
- ❑ Warts
- ❑ Whooping cough
- ❑ Worms
- ❑ Yellow fever
- ❑ Other _____

Any other major conditions not listed here?

I have never been well/the same since….. (illness, event, etc.):

List any surgeries or medical procedures & dates:

What medications are you allergic to, if any?

List any vivid, characteristic, or repeating dreams you have now or have had in the past.

Please list any stresses or events that profoundly affected you, or altered the course of your life:

Make a timeline on the back of this sheet to organize your life's impactful events.

Food Desires/Aversions

Indicate your strong food cravings or aversions by using this scale:
(No need to rate foods you feel neutral about, add notes below if needed)

Very averse -3 -2 -1 ← Neutral → 1 2 3 Crave

___Chocolate
___Salty
___Spicy
___Eggs
___Rich Foods
___Sweets
___Vinegar
___Dressings
___Pickles
___Cheese
___Cream
___Butter
___Ice cream
___Milk
___Yogurt
___Beef
___Chicken
___Pork
___Fish
___Smoked meat
___Meat fat
___Tea
___Coffee
___Beer
___Wine
___Liquor
___Ice
___Warm drinks
___Cold drinks
___Carbonated drinks
___Indigestible things
___I do not like to eat
___I have no cravings