Providence Wholistic Healthcare

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Client Intake and Health History – Homeopathic Addendum - Review of Systems

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (cell)__ _____

Age _____ Date of Birth _____ Gender: Female Male

Education _____Email:_____

Married ____Partnership ____Separated ____Divorced ____ Widowed ____ Single _____

Live with: Spouse _____ Partner ____ Parents ____ Children ____ Friends ____ Alone ___

Occupation _____ Hours per week _____

Circle Y - a condition you have **P -** a condition you have had before **N -** never had this condition

Skin:

Warts	Y	P	N
Rashes	Y	P	N
Eczema	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Color Change	Y	P	N
Lumps	Y	P	N
Night sweats	Y	P	N

Head:

Headache	Y	P	N
Head injury	Y	P	N

Eyes:

Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing/dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N

Ears:

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earaches	Y	P	N
Dizziness	Y	P	N

Respiratory:

Constriction	Y	P	N
Cough	Y	P	N
Sputum	Y	P	N
Spit up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Difficulty breathing	Y	P	N
Emphysema	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
-at night	Y	P	N
-when lying down	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular:

Heart Disease	Y	P	N
Angina	Y	P	N
High Blood Pressure	Y	P	N
Murmurs	Y	P	N
Swelling in ankles	Y	P	N
Chest Pain	Y	P	N
Palpitations	Y	P	N

Nose/Sinuses:

Gastrointestinal:

Frequent colds Y P N
Nose bleeds Y P N
Stuffiness Y P N
Hay fever Y P N
Sinus problems Y P N

Mouth/Throat:

Frequent sore throat Y P N
Canker sores Y P N
Sore tongue Y P N
Gum problems Y P N
Hoarseness Y P N
Dental cavities Y P N

Neck:

Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N
Trouble Swallowing Y P N

Urinary:

Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

Female reproductive:

Age menses began: _____
Average # of days long: _____
Total days in cycle: _____
Bleeding between Y P N
Are cycles regular Y P N
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Birth control Y P N
Type: _____
# of pregnancies: _____
# of live births: _____
# of miscarriages: _____
# of abortions: _____
Difficulty conceiving Y P N
Menopausal symptoms Y P N
Sexually active Y P N
Venereal disease Y P N
Age Menses Ceased _____

Liver disease Y P N
Heartburn Y P N Ulcers Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomit blood Y P N
Hemorrhoids Y P N
Belching/gas Y P N
Gall bladder Disease Y P N
Blood in stool Y P N
Bowel movement, how often: ___

Musculoskeletal:

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms/cramps Y P N
Weakness Y P N
Bone disease Y P N
Osteoporosis Y P N

Peripheral vascular:

Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombophlebitis Y P N

Neurologic:

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness/tingling Y P N
Loss of memory Y P N

Emotional:

Depression Y P N
Mood swings Y P N
Anxiety/nervousness Y P N
Tension Y P N

Endocrine:

Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N

Blood problems Y P N

Easy bruising Y P N
Anemia Y P N

Breasts:

Self breast exam Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

Male reproductive:

Prostate disease Y P N Testicular masses Y P N
Hernias Y P N Testicular pain Y P N
Venereal disease Y P N Sexually active Y P N
Discharge or sore Y P N Erectile dysfunction Y P N