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

Nose/Sinuses:

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

Gastrointestinal:

	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

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 _____

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