North Star
HOMEOPATHY
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Date: _____

Client Name: _____

Date of birth: _____

Address: _____

_____

_____

Email: _____

Phone: _____

Parent/Guardian name (if minor): _____

Parent/Guardian contact info (if different from above): _____

_____

Occupation:_____

Primary Health Concerns:

1. _____
2. _____
3. _____
4. _____

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FAMILY HEALTH HISTORY

Please list any major health issues for the following blood relatives of the client:

Alcohol/drug problem, Allergy/Asthma, Anemia, Arteriosclerosis, Arthritis, Binge Eating/Bulima, Bleeding Problem, Cancer, Diabetes, Epilepsy/seizure, Heart disease, High blood pressure, High cholesterol, Kidney disease, Liver disease, Mental illness, Obesity, Stroke, Suicide, Thyroid disease, Tuberculosis, Ulcer, Syphilis, Skin disease, Gonorrhea, Other

Paternal Grandfather	Paternal Grandmother	Father	Mother	Maternal Grandfather	Maternal Grandmother

HISTORY OF CLIENT ILLNESS, INJURY, AND MEDICAL PROCEDURES:

Hospitalizations: Reasons and Dates

_____

Surgeries: Procedures & Approximate Dates

_____

Serious Illnesses:

_____

Accidents / Traumatic Injuries / Broken Bones:

_____

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Current Medical Diagnoses, if any:

CURRENT MEDICATIONS / SUPPLEMENTS	TREATMENT FOR	YEAR / DATE STARTED

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HEALTH CONDITIONS

Please check off all that apply to you and list approximate dates/ years.

- ☐ Acne _____
- ☐ AIDS _____
- ☐ Alcohol / Drug Problem _____
- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Antibiotics (>/= 1x a year) _____
- ☐ Anorexia / Bulimia _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Back problems _____
- ☐ Binge Eating _____
- ☐ Bladder Infections _____
- ☐ Blood Clots _____
- ☐ Bronchitis _____
- ☐ Cancer _____
- ☐ Cataract(s) _____
- ☐ Chemical Sensitivity _____
- ☐ Chronic Fatigue _____
- ☐ Colitis _____
- ☐ Depression / Anxiety _____
- ☐ Diabetes _____
- ☐ Ear Infections _____
- ☐ Eczema _____
- ☐ Endometriosis _____
- ☐ Fibroids (Uterine) _____
- ☐ Gallbladder _____
- ☐ Glaucoma _____
- ☐ Gout _____
- ☐ Hearing Problems _____
- ☐ Heart Attack _____
- ☐ Heart Failure _____
- ☐ Hemorrhoids _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ Hernia _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Hives _____
- ☐ Insomnia _____
- ☐ Kidney Infections / Stones _____
- ☐ Liver Disease _____
- ☐ Menstrual Problems _____
- ☐ Mental Illness _____
- ☐ Migraines _____

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- ☐ Mononucleosis _____
- ☐ Mumps _____
- ☐ Neurological Problems _____
- ☐ Nightmares / Night Terrors _____
- ☐ Overweight _____
- ☐ Panic Attacks _____
- ☐ Pelvic Infection _____
- ☐ Periodontal Disease _____
- ☐ Phlebitis _____
- ☐ Pneumonia _____
- ☐ Premenstrual Problems _____
- ☐ Psychotherapy _____
- ☐ Rheumatic Fever _____
- ☐ Scarlet Fever _____
- ☐ Seizures / Epilepsy _____
- ☐ Sexually Transmitted Infections _____
- ☐ Sinusitis _____
- ☐ Sleep Disorder _____
- ☐ Steroid Use _____
- ☐ Stroke _____
- ☐ Suicide Attempt _____
- ☐ Syphilis _____
- ☐ Thyroid Problems _____
- ☐ Tuberculosis _____
- ☐ Ulcer _____
- ☐ Vaccine Reaction _____
- ☐ Warts _____

Additional note space (if needed):

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LIFESTYLE

Allergies	**Food Allergies** (include method of testing)
Food Cravings	**Alcohol / Recreational Drug Use** – Do you drink alcohol or use drugs? How much / often?
Caffeine – Do you drink coffee or tea? How much / often?	**Do you smoke now or did you in the past?** How much / often?
Diet Soda / Artificial Sweeteners – Describe your use	**Refined Sugars / Processed Foods** – Describe your use
Hobbies – List any. How often do you do them?	**Living Situation**
Exercise – Describe the ways you get your body moving. Do you feel you get enough physical activity?	**Food** – Do you fee you eat a healthy and well-balanced diet? Do you need guidance / support?
Worry / Anxiety – Do you have particular issues that worry you? How does this impact your life?	**Healthy Relationships** - Do you have a supportive family / community?

Unhealthy Relationships – Have you been a victim of domestic abuse or troubling relationships?	**Intimacy** – Are you satisfied with your sexual / intimate life?

Anything else? Please indicate any other topics you want to address in your consultation.

LIFE CHANGES - In the past year, what changes have occurred in your:

Personal Life:
Family Life:
Social Life:
Work Life:
Any other changes:

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Hormonal Health (Check all that apply or answer as applicable):

Male
☐ Enlarged prostate
☐ Decreased urine stream
☐ Unable to interrupt stream
☐ Dribbling after urination
☐ Pus or drainage from penis
☐ Genital swelling
☐ Rash/eruptions
☐ Problems with sexual function

Female
Date of last menstrual period _____
Length of cycle _____
Length of period _____
Age menstruation began _____
Menopause (list date) _____
Number of pregnancies _____
Number of live births _____
Number of abortions/miscarriages _____

Check all that apply:
☐ Vaginal discharge
☐ Spotting between periods
☐ Painful intercourse
☐ Issues with fertility
☐ Problems with sexual function