INTEGRAL HEALTH CLINIC

www.integralhealthclinic.com

Homeopathy and Naturopathy Long Intake

Dr Shahram Ayoubzadeh

Please return this form to our office at least 2 days prior to your visit to allow Dr Shahram Ayoubzadeh the time to read it.

N.B. Only complete this form if you are requested to do so by Dr Shahram Ayoubzadeh, otherwise please complete the *short* form.

Personal information **Date**: _____

Name:_____ _____ Date of Birth: _____

Present Weight: _____ Normal Weight: _____When last this weight? _____

Name of family medical doctor: _____

What is your chief concern about your health? _____

_____

_____

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PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here to get well. We are here to select the possible medicine for you. In order to do that, we depend on your co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order find all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is useless. Even something that you may think is not connected with your health issues may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give us the fullest possible information on each point*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential.

THIS QUESTIONNAIRE HAS 8 PARTS:

1. Your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
2. History of your present illness.
3. About all the parts of your body.
4. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and tell us what specific effects they have on you.
5. About your mental state and your emotional nature. In this part write about your situation in life and about all the things that are bothering you. Be totally frank and open.
6. About your sleep and dreams.
7. For children or how issues you had as a child.
8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

Previous Disease and Medications taken

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus your body is strengthened. Thus it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, check mark ALL major illness so far suffered and on the next page give its relevant details.

Typhoid Cholera Food poisoning Worms Diarrhoea Dysentery	Measles German Measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver Spleen or Gall bladder disease	Miscarriage Abortion Curetting Sickness during Pregnancy etc. Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Any venereal disease like Syphilis, Gonorrhoea etc.	Any heart trouble, Blood pressure, Giddiness	Nephritis, Kidney or urine trouble Diabetes etc. Prostate trouble
Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles Uterus, Renal stones, Gall stones, Phimosis, Hydrocele, Cataract etc. Mode of anaesthesia : General or local	Diphtheria Septic Tonsils Sinusitis Adenoids Recurrent infections Bronchitis Eosinophilia Cold-Fever-Chill Pneumonia Asthma Pleurisy T. B.		Any serious shock, grief, disappointments, fright, mental upset, depression or nervous break down.
Chronic Headaches, Numbness, Cramps, Fits, Convulsions Polio, Paralysis etc. Meningitis Any Lumbar puncture done.	Any major accident or injury to body or head. Any occasion of unconsciousness. Any major bleeding from any part of the body.		Skin diseases Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Herpes, Urticaria, Allergy. Ulcers on any part of the body.

Diseases / symptom	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars
IBS, constipation, bloating					
Headaches, anaemia					
Allergies					
Trichomonas, herpes, Chlamydia					
Kyphosis, scoliosis, lordosis					
Kidney crisis, stone, hydronephrosis, interrupted stream					
Torn meniscus					
Ovarian cyst, polyps					
Endometriosis					
Restless leg syndrome, lead to insomnia					

Include in the table above any drugs, tonics, stimulants etc. that have been used by you at any time in life

FAMILY INFORMATION

Major diseases in your family
Anaemia
Cancer
Diabetes
Insanity
Rheumatism
T. B. / Pleurisy
Leprosy
Epilepsy / Fits
Bleeding tendency
Urticaria
Eczema
Asthma
Paralysis
Hypertension
Heart trouble
Kidney disease
Liver disease etc.

Relationship	Alive / Dead	Age	Diseases suffered	Cause of death
Paternal Grand Father				
Paternal Grand Mother				
Maternal Grand Father				
Maternal Grand Mother				
Father				
Mother				
Paternal Uncle				
Paternal Aunts				
Maternal Uncle				
Maternal Aunts				
Cousin Brother & Sister on Father's Side				
Cousin Brother & Sister on Mother's Side				
Did any of your relatives have trouble similar to yours				

Provide information about your brothers and sisters, include those who died, if any.
Indicate your position by writing ‘SELF’.

Sr. No	Brother / Sister	Alive?	Age	Diseases Suffered
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PERSONAL HISTORY

Did your mother have any problem during pregnancy?

Did she take any drugs during pregnancy? What were they?

Was there any difficulty about your birth? Give Details.

Did you have problems such as bed wetting?	
Did you eat indigestibles like chalk, lime, earth, slate-pencil etc.	
Any other problem about your growth & development?	

How old were you when you started

Teething _____ Sitting _____ Standing _____ Walking _____ Talking _____

Have you ever been bitten by a Dog _____ Rat _____ Snake _____ Scorpion _____ Other (what) _____

Did you take anti-rabies or anti-venom or any other treatment? _____

Vaccination & Inoculations:

Indicate number of times you were vaccinated for the following:

Small-pox _____ Polio_____ Cholera _____ Measles _____Triple _____B. C. G. _____ Typhoid _____Tetanus _____

Was there any reaction or particular trouble after any of above vaccination or inoculations (give details)?

If married or common law, how is the health of your husband/wife?

Children living and dead. If dead, state causes. Mention ages of children and their condition of health.

Child's Name	Male/Female	Age	Disease Suffered

Any abortions, miscarriages or still births?

Habits - how much, if any of the following do you use?

Smoking	
Snuff	
Chewing tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives / Purgatives	
Any other	

List your main complaints and troubles, their history, onset and course, including dates if possible (continue overleaf if needed).

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (E.g. Shock, worry, errors in diet, over-exertion, over-exposure to cold, heat etc.)? If so what?

_____

_____

APPETITE AND THIRST

How is your appetite?

When are you hungry?

What happens if you have to remain hungry for long?

How fast do you eat?

How much thirst do you have?

Any particular time when you are you specially thirsty?

Do you feel any change in your taste and feeling in your mouth?

Please mark whether you like/dislike the following foods or if they disagree with you. Use X if it is a mild reaction, XX for a strong reaction.

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Bitter				Eggs			
Salt extra				Spicy food			
Sweet				Meat			
Sour				Fish			
Bread				Cabbage			
Butter				Onions			
Fats				Warm food / drink			
Milk				Cold food / drink			
Coffee				Fruits			
Mud / Chalk				Anything else:			

STOOL

Do you have any problem regarding your stools?

When and how many times a day you pass stools?

When is it urgent?

Do you have any problem about bowel movements?

Do you have to strain for stool? Even if soft?

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas (up or down)?

URINATION & URINE

Any problem about urine?

Any strong smell? Like what?

Do you have any trouble before, during and after passing urine?

Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling etc.?

Any involuntary urination? When ?

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat?

Where and on what part do you sweat most?

Do you perspire on the palms or soles?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?

What is the smell like? e.g. foul, pungent, sour, urinous.

What colour does it stain the clothing?

Is the stain easy to wash off or difficult?

Any symptoms after sweating?

When do you get fever or chill?

What brings it on?

Do you experience any sense of heat or cold in any part of your body at any particular time?

Do you have burning or heat in your palms or soles?

CHEST - HEAT - COLD - COUGH

Do you catch cold often, if so, how often?

Describe the symptoms, nature of any discharge etc.

Is there any trouble with your CHEST or HEART?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

Do you have cough?

Is it more at any particular time?

SEXUAL SPHERE - GENERAL

Any excessive indulgence in sex in past and present?

Any effect on your health?

How do you feel after sexual intercourse?

Any particular feeling or symptoms appear before, during or after sexual intercourse?

Do you suffer from any sexual disturbance?

Any habit (masturbation etc.) in past or present? How often?

Any homosexual inclination?

Did you, or do you suffer from any sexually transmitted disease? Syphilis? Gonorrhoea? Herpes? HIV?

Did you have increased desire or decreased desire for sex?

What is the method you use for family planning (contraception)?

FOR MEN

Any difficulty in erection? Wanted erection? Unwanted erection? Weak erection? Failing erection? Describe.

Any other trouble with sexual intercourse? Describe.

FOR WOMEN

Menses: How are the periods; regular or irregular?

At what age did you start?

Was there any trouble then?

How long between two periods.

How many days of flow.

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

Are the stains difficult to wash?

Have you noticed any variation in quality and quantity of flow during menses? How and when?

Do you suffer in any way before, during or after menses? If so, describe:

What symptoms did you suffer during menopause ?

Do you feel internal parts coming down? Prolapse ?

Is there any white discharge?

Describe the nature, colour, consistency and smell of any discharge.

When and under what circumstances is it more or less?

Has the discharge any relation to menses?

What is the effect of this discharge on your general feeling, or any of your symptoms?

Any itching, excoriation etc. due to discharge?

Do you pass any gas from vagina?

Any trouble with your breasts? Describe.

DESCRIBE ANY COMPLAINTS YOU HAVE ABOUT THE FOLLOWING

VERTIGO - Do you have giddiness – vertigo?

FAINTNESS: Do you ever feel faint?

HEAD: Do you get headaches?

EYES & VISION

EARS & Sense of hearing:

NOSE & Sense of smell:

FACE & Facial expression:

MOUTH, TONGUE & Sense of taste:

TEETH, GUMS, e.g. carious teeth, bleeding gums, swollen gums.

LIPS: Cracked, peeling of skin etc.

THROAT (including tonsils):

Any difficulty in swallowing?

Do you have any trouble in your BACK, LIMBS OR JOINTS? Describe in detail:

If you have pains, do they shift?

In what direction do they extend ?

Is there any abnormality, swelling, numbness, paralysis etc. in any part of the body?

Is there any complaint of SKIN: such as itching, eruptions ulcers, warts, corns, peeling etc.? Describe it.

Any change in colour of the skin or spots of any part of the body?

Is there any complaint or abnormality of the NAILS or skin around?

Is there any complaint with the HAIR such as falling, greying, dandruff, dryness, oily, poor excessive or unusual growth?

Do wounds heal slowly? _____Do you get cheloid scarring? _____

Do wounds tend to form pus? _____Have you a tendency to bleed? _____

Are your troubles one sided, if so which one?

Or more on one side, if so which one?

Do they proceed from one to the other side?

Do they alternate or shift?

Is there any trembling, if so when?

Is there any senses of weakness, if so where?

When is it more or less?

Is it in any particular part of the body?

FACTORS THAT AFFECT YOU

Below is a list of things to which you can be exposed. Each of these factors may affect you in a particular way. Look at the list and write in the way in which you are affected by each of them. Does the exposure make you feel better or worse, in what way does it affect you?

For instance take the factor “sun”. Suppose by going in the sun you get a headache then write “Headache” in the column next to “Sun”.

Take another example: If in hot weather you feel uneasy, then write “Uneasy” in the column next to “Hot Weather”.

It is particularly important that you include the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then in the column next to “lying on the back” write “Asthma worse”.

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause a headache but make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

	Effect
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunder storm	
Sun	
Covering	
Warm bath	
Cold bath	
Walking	
Running	
Climbing stairs	
Going down stairs	
Riding in bus, car etc.	
Lying	
Lying on back	
Lying on abdomen	
Lying on left side	
Lying on right side	
Lying with head low	
Sitting	
Sitting erect	
Standing	
Looking up	
Looking down	
Looking from up high	
Looking from moving car etc	
Noise	
Sudden Noise	
Music	
Light	
Strong Smells	

When constipated	
Before Urine	
During Urine	
After Urine	
Before Menses	
During Menses	
After Menses	
After Sweating	
When Fasting	
After eating	
Drinking	
After Sweating	
Dust	
Smoke	
Touch	
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After Weeping	
Consolation / Sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Full Moon / New Moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Biting or chewing	

Blowing Nose	
When alone	
In company	
Physical exertion	
Belching	
Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Moonlight	
Opening the mouth	
Smoking	
Hanging the limbs	
Raising the arms	
Near Sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Over eating	
Working in water	
Fanning	

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole.

In order to understand *you* we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental makeup.

Answer freely. Answer frankly. Answer completely.

Are you anxious? About which matters?

Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.? What things?

Are you doubtful or suspicious? Of what?

What are you jealous about? Of whom?

From what symptoms do you suffer when jealous?

In which matter are you impatient? Hurried?

How long do you remember hurts caused to you by others?

How revengeful are you?

What are you proud of? Does your pride get easily hurt?

Do you get depressed, brooding, etc.?

Do you ever become suicidal? When?

If so in what manner do you contemplate to end your life?

Even then, are you afraid of dying?

When are you cheerful?

Are you sexual-minded?

Any unwanted thoughts any time? What are they?

Have you any imaginary sensations or fears?

Do you hear voices, or that you are called, or anything else such as this that keeps on occurring in your mind unduly?

How is your memory? For what is it poor? e.g. names, places, faces, what you have read, etc.

Do you weep easily?

What makes you weep? How do you feel after weeping?

How do you feel if someone offers sympathy and consolation?

Are you easily irritated? What makes you angry?

What bodily symptoms do you develop when angry? e.g. trembling, sweating etc.

Do you like company? Or like to remain alone?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What are the greatest griefs that you have gone through in your life?

What are the greatest joys that you have had in life?

What activities you deeply like?

What activities or things do you deeply dislike?

In your opinion, which aspects of your mind and moods are not agreeable to you?

In spite of your awareness and maturity, are you unable to change these aspects?

Give a clear picture of your situation in life and your relationship with each of your family members, friends and associates in work.

How does the future look to you?

When you are free, what thoughts come to your mind?

Are you worried or unhappy over any personal, domestic, economical, social or any other condition? If so describe in detail (continue overleaf if necessary):

If asked for 3 desires or wishes in life, what would you ask for?

SLEEP

Describe your posture in sleep, on the back, side, abdomen etc.

Are you able to sleep in any position?

Any position in which you cannot sleep?

During sleep do you:

Snore _____Grind teeth _____ Dribble saliva _____ Sweat _____

Keep eyes or mouth open _____ Walk _____ Talk _____ Moan _____

Weep _____ Become restless _____ Wake up with a jerk _____

Describe anything else that is unusual about your sleep, and if so when it happens

How much do you cover yourself up when sleeping?

Do you have to uncover any parts of your body?

DREAMS

Circle or put an X beside the types of dream that you have. Please emphasise repetitive dreams

Animals	Robbers	Travelling	Houses	Death, Whose?
Cats - Dogs	Thieves	Riding	Fruits	Dead bodies
Horse	Anxious	Flying	Trees	Dead persons
Wild animals	Fearful	Swimming	Water	Part of Body
Snakes	Ghosts	Drowning	Snow	Suicide
Being Hungry	Fire	Accidents	Talking	Business
Being Thirsty	Lightning	Falling	Singing	Money
Drinking	Storm	Shooting	Dancing	Day's work
Eating	Rain	Wars	Pleasant	Forgotten work
Vomiting	Romantic	Pain	Praying	Failure / Exams
Passing stool	Sexual Pleasure	Illness	Religious	Unsuccessful efforts For what?
Urinating	Rape	Sickness	Temple	
Blood-bleeding	Nakedness	Mutilations	Church	Missing Train
Excrements / Soiling			God	Being unprepared
Grief	Police	Misfortunes	Of people	Of events
Weeping	Imprisonment	Insecurity	Children	Remote
Vexation	Crime	Danger	Parties	Recent
Quarrels	Murder	Being pursued	Feasts	Future
Jealousy	Killing	- By whom?	Marriage	Prophetic
Insults	Poison	- For what		
Physical Exertion	Mental Exertion	Fatigue	Coloured	Multi-Coloured

If any other, specify below:

Please draw something that comes to your mind at present (spontaneous drawing or doodling) or your favourite drawing:

FOR CHILDREN OR YOU AS A CHILD

Please mark once X if the child or you as child had any of the following qualities. Mark twice XX if they are more intense

	mark here		mark here
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like :-	
Hyperactivity		Biting nails	
Destructiveness		Thumb-sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition - winning spirit		(b) shawls, handkerchiefs	
Sibling jealousy		(c) anything else	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness / Indolence	
Telling lies		Sensitive / Emotional	

Please describe in detail any physical or emotional stress suffered by the mother during pregnancy. Also describe the dreams the mother had during pregnancy.

Please describe any other aspects you feel are striking about the child or your childhood

Describe one particularly upsetting incident experienced by the child or during in your childhood.

YOUR COMPLAINTS

How to describe your complaints

In homoeopathy prescription is based on precise details of various symptoms from which you suffer. To tell a homoeopathic physician that you “have a headache”, “an eruption”, or “cough”, would not be enough. If you inform him “I have a headache with sharp shooting pains in the left side of my head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when getting up, walking about or when the head becomes cool”, then you have now given all the information required for making a good homoeopathic prescription. *The success of the prescription depends largely on how detailed your description of the symptoms can be.*

We require the following details about your symptoms.

LOCATION: Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure below to indicate location.

SENSATION: Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand, or you may have a pain which is cutting, burning, jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on pages 17 to 19. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES: You may have a discharge from ulcers, fistula, eruptions the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects.

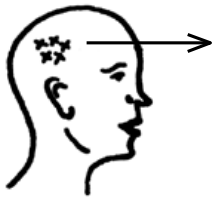
The quantity and the time or condition under which the quantity varies i.e. when it is better or worse, increases or decreases ?

The consistency; Is it thin or thick, stringy, or clotted? Is it like jelly, white of an egg, like water, sticky, forming a scab etc?

The odour, what does it remind you of ?

Does it make the parts sore, and in what way?

Please mark in the below figure, the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of you head please mark as shown →

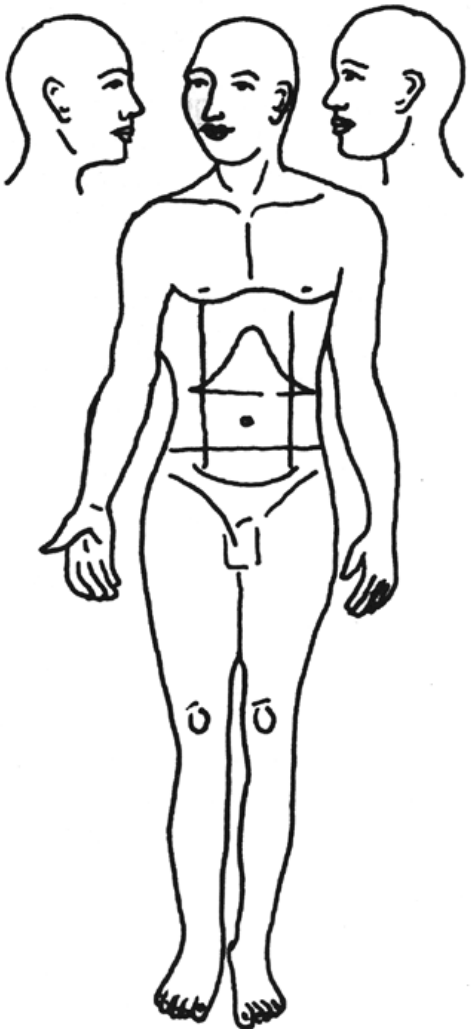


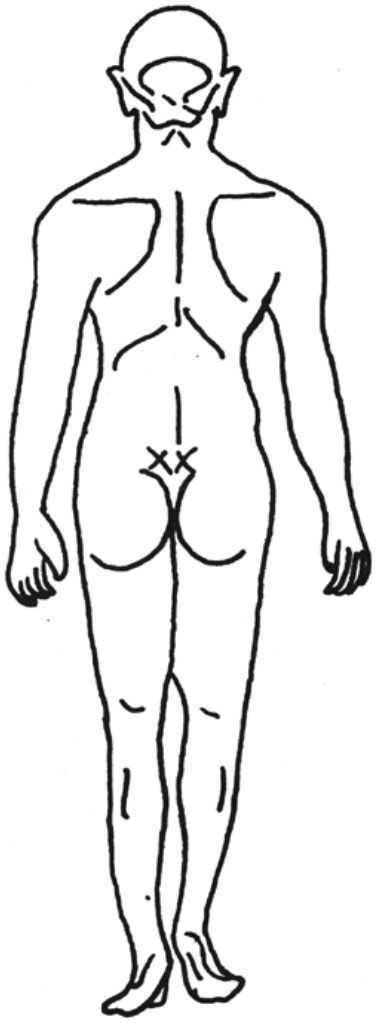
RIGHT FACE

FRONT

LEFT FACE

BACK





PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAIL IN THE MANNER DESCRIBED ON PAGE 29

COMPLAINT NO.	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE

Thank you for taking the time to complete this questionnaire. It will help us considerably in determining the correct remedy for you. Once completed it is confidential.

CANCELLATION POLICY

We try to provide exceptional service to our patients. To help us achieve this we ask that you provide us with at least 48 business hours notice if you need to reschedule or cancel your appointment. This enables us to make your time slot available to others who may need to see us, and to be able to maintain our consultation fees at the present rate.

Appointments missed or cancelled without 48 business hours notice inconvenience us and our patients, and we reserve the right to charge you for the appointment if we cannot allocate the time reserved for you to another patient.

Even though we try our best to send you a reminder by phone or via email, it is ultimately your responsibility to remember your scheduled appointments.

We will be there for you at the time reserved for you, we hope you can be there too.

Signed (patient or guardian): _____ Date (mm/dd/yy): _____

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