BLACKBIRD HOMEOPATHY

Name _____ Date _____

Occupation _____

Education _____

Date of Birth _____ Age _____ Gender __ Blood Type _____

How did you hear about Blackbird Homeopathy?

_____

Family History

	First name	Age	If passed, cause of death
Father			
Mother			
Siblings			
Children			

Check the Items that apply to blood relatives, and list relationship.

□ *Alcohol/drug problem*
□ *Allergy/Asthma*
□ *Anemia*
□ *Arteriosclerosis*
□ *Arthritis*
□ *Binge Eating/Bulimia*
□ *Bleeding Problem*
□ *Cancer*
□ *Diabetes*
□ *Epilepsy/seizure*
□ *Heart Disease*
□ *Skin Disease*
□ *Gonorrhea*
□ *High Blood Pressure*
□ *High Cholesterol*
□ *Kidney Disease*
□ *Liver Disease*
□ *Mental Illness*
□ *Obesity*
□ *Stroke*
□ *Suicide*
□ *Thyroid Disease*
□ *Tuberculosis*
□ *Ulcer*
□ *Syphilis*

BLACKBIRD HOMEOPATHY

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

□ **Acne**	□ **Endometriosis**	□ **Nightmares**
□ **AIDS**	□ **Fibroids (uterine)**	□ **Overweight**
□ **Alcohol/drug problem**	□ **Gallbladder**	□ **Panic Attack**
□ **Allergies**	□ **Glaucoma**	□ **Pelvic Infection**
□ **Anemia**	□ **Gout**	□ **Periodontal Disease**
□ **Antibiotics (1x a year)**	□ **Hearing Problems**	□ **Phlebitis**
□ **Anorexia/Bulimia**	□ **Heart Attack**	□ **Pneumonia**
□ **Anxiety**	□ **Heart Failure**	□ **Premenstrual Tension**
□ **Arthritis**	□ **Hemorrhoids**	□ **Prostrate Problems**
□ **Asthma**	□ **Hepatitis**	□ **Psychotherapy**
□ **Back Problems**	□ **Herpes**	□ **Rheumatic Fever**
□ **Binge Eating**	□ **Hernia**	□ **Scarlet Fever**
□ **Bladder infections**	□ **High Blood Pressure**	□ **Seizures/epilepsy**
□ **Blood clots**	□ **High Cholesterol**	□ **STI's**
□ **Breast lumps**	□ **Hives**	□ **Sinusitis**
□ **Bronchitis**	□ **Insomnia**	□ **Sleep Disorder**
□ **Cancer**	□ **Kidney Infection/stones**	□ **Steroid Use**
□ **Cataract (s)**	□ **Liver Disease**	□ **Stroke**
□ **Chemical Sensitivity**	□ **Menstrual Problems**	□ **Suicide Attempt**
□ **Chronic Fatigue**	□ **Mental Illness**	□ **Syphilis**
□ **Colitis**	□ **Migraine**	□ **Thyroid Problem**
□ **Depression/Anxiety**	□ **Mononucleosis**	□ **Tuberculosis**
□ **Diabetes**	□ **Mumps**	□ **Ulcer**
□ **Ear Infection**	□ **Neurological Problem**	□ **Vaccine Reaction**
□ **Eczema**		□ **Warts**

Surgeries: List all procedures and approximate dates	**Hospitalizations**: Reasons/Dates

Accidents, Traumatic Injuries, Broken Bones:	**Current Health Problem/Diagnosis:**

Male	**Female**
Enlarged prostate?	Date of last menstrual period:
Decreased urine stream?	Length of cycle
Unable to interrupt stream?	Length of period
Dribbling after urination?	Age menstruation began:
Pus or drainage from penis?	Menopause?
Genital swelling?	Number of pregnancies
Rash/eruptions?	Number of live births
Problems with sexual function?	Number of abortions/miscarriages
	Vaginal discharge?
	Spotting between periods?
	Painful intercourse?
	Issues with fertility?
	Problems with sexual function?

Lifestyle

Prescription Medications (List prescribing doctor), include dosage & frequency	**Vitamins/Mineral Supplements, including dosage and frequency.**
Environmental Allergies	**Food Allergies (include method of testing)**
Food Cravings	**Alcohol/Cannabis/Recreational Drug Use** Do you drink alcohol or use drugs? How much/often?
Caffeine Do you drink coffee or tea? How much/often?	**Cigarettes** Do you smoke now or did you in the past? How much/often?
Environment Do you have any past or present potential work or living exposures, i.e. factory, farm, military service, lab, RF electronics?	**Refined Sugars/Processed Foods:** Describe your use:

Hobbies 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 feel 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?	**Spiritual Life:** Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory?
Intimacy: Are you satisfied with your sexual/intimate life?	**Anything else?** Please indicate any 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:
Sex Life:

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