Name: _____ **Date:** _____

HOMEOPATHIC QUESTIONNAIRE

Please circle the answers to the corresponding statements as honestly and accurately as possible. Some of these questions may not seem directly related to your health concerns, however they will help us find the best homeopathic remedy for you. Feel free to add explanations to your answers if you so choose.

WEATHER

Cold weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Rainy or humid weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Hot weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Change of weather affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Wind or thunderstorms affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Without a hat or sunglasses, I can tolerate exposure to 75F sun for a duration of
10 min. or less 10-30 min. 30-60 min. 1-2 hours 2-4 hours 4 hours or more

I generally feel better in the following atmosphere/weather
Mountains Seashore Dry weather Rainy/Stormy weather Sunny weather Cloudy weather

My symptoms get worse during the following seasons:
No season affects my symptoms Spring Summer Fall Winter
If so, which symptoms worsen? _____

ENVIRONMENT

Bright light affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Warm rooms affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Cold open air affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Loud noise affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Cold drafts affect me negatively (fans, A/C, wind)
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Perfumes, flowers, food smells, or other strong odors affect me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

TIME OF DAY

The time of day that I generally feel the **best** or the most energetic is _____ AM/PM until _____ AM/PM

The time of day that I generally feel the **worst** or have the lowest energy is _____ AM/PM until _____ AM/PM

Name: _____ **Date:** _____

GENERAL PHYSICAL CHARACTERISTICS

I tend to become uncomfortable faster in a room that is
Warmer than usual (80 degrees) Cooler than usual (60 degrees) (Circle the one that tends to bother you more)

Tight clothing affects me negatively (If so, around what part of the body? _____)
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

During sleep, I experience the following
Restlessness Sleep walking Teeth grinding Uncovering Perspiration Heat Coldness Snoring
Strange dreams Talking in sleep Frequent urination Frequent waking (at a specific hour?_____)

My usual sleep position is
On back On abdomen On side (right or left?) Feet/arms uncovered Fully covered Head also covered

In general, I tend to perspire
Never Only with exertion When heated When cold When nervous Easily, all the time

The part of my body where I tend to perspire the most is _____

FOOD & DRINKS

I crave the following flavors strongly on a daily basis (you may circle more than one)
Sweet Salty Sour Spicy Bitter Smoked Pungent

I crave the following types of food or drinks strongly on regular basis (you may circle more than one)
Apples Bacon Beer Bread Butter Cake/Cookies Cheese Chocolate Coffee Eggs Fish
Fresh fruit Fried food Frozen food Garlic Ham Ice Ice cream Indigestible things (clay, chalk, etc.)
Lemons/Lemonade Liquor Meat Milk Nuts/Nut butters Onions Olives Oranges Pastries Pickles
Potatoes Salsa Sausage Shellfish Tea Vegetables Wine Other: _____

If all food were healthy, I would enjoy the following foods/drinks multiple times per day:
_____

I tend to dislike the following foods, drinks, or flavors:
_____

With regard to thirst, on an average temperature day without physical exertion, I feel the need to drink water or another beverage to quench my thirst
Almost never Several times per day Several times per hour Every few minutes

I prefer my water
Hot Room temperature Cold Ice cold

I prefer my food
Hot Cold No strong preference

FEARS

I have a strong fear of:

Darkness	Becoming seriously ill	Knives or needles
Thunderstorms	Loved one becoming ill or injured	Blood
Heights or falling	Ghosts	Spiders or insects
Small or narrow places	Evil	Snakes
Strangers	Failure	Animals (what kind? _____)
Robbers/intruders	Poverty	Being alone
Water, lakes, or the ocean	Death	Being in public or in a crowd
Contagious disease/germs	Insanity	That something terrible will happen

Other fears or phobias:_____

Name: _____ **Date:** _____

MENTAL & EMOTIONAL CHARACTERISTICS

In general, I tend to feel restless
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

In general, I tend to be perfectionistic
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

In general, I tend to feel impatient or hurried
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

In general, I tend to feel suspicious
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

In general, I tend to feel jealous or envious
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

In general, I tend to feel irritable or angry (whether you express it or not)
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to criticize myself
Almost never Less than once a week Once a week Once a day More than once a day

In general, I tend to criticize others (either verbally or in my thoughts)
Almost never Less than once a week Once a week Once a day More than once a day

I think about disagreeable or troubling events from the past
Almost never Less than once a week Once a week Once a day More than once a day

I have urges to throw things, hit people/things, or break things (whether you act on this desire or not)
Never/Almost never Less than once a week Once a week Once a day More than once a day

I have urges to hurt myself (whether you act on this urge or not)
Never/Almost never Less than once a week Once a week Once a day More than once a day

I cry easily or often
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

If someone upsets or offends me, I feel nervous confronting that person about it
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree Only with authority figures

I am offended easily by rudeness or injustice
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am overly sensitive to hearing sad or cruel stories about children, adults, or animals
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Being scolded or criticized affects me negatively
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am frightened or startled easily
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I often worry about social status and success
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I often feel impulsive, or have sudden changes in mood or behavior
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

Name: _____ **Date:** _____

I have difficulty making decisions
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have a strong desire to travel or to be outdoors in nature
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I have a strong religious or spiritual faith
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

I am often forgetful of the following
Dates Names Numbers Words Places Faces Recent events Distant past events
What I was about to say What someone just told me What I was about to do What I just did What I just said

I have had dreams or daydreams that have come true (clairvoyant or prophetic dreams)
Less than twice Less than 4 times Less than 10 times More than 10 times

Regarding any past emotionally traumatic events, I feel
Grief Guilt Anger Fear Sadness Shame Indifference Peace Empowerment
Other: _____

Regarding my health condition, and the possibility of recovery, I feel
Very optimistic Hopeful Somewhat doubtful Discouraged Fearful Severe despair

In general, my overall outlook on life at this time is
Very optimistic Generally positive Indifferent Pessimistic
Loathing life Desire death Suicidal thoughts Suicidal plans

When I am feeling sad or upset, at the very worst point, I need
To be completely alone To have someone nearby To be distracted from my feelings
To vent about what I am feeling To have someone talk to me about what I'm feeling, and console me

If I am feeling at my worst, the following makes me feel much better (circle any that apply)
Rest/Sleep Massage Crying Yelling Music Dancing Singing
Company Being alone Talking Quiet Darkness Light/Sunshine Eating
Gentle exercise Vigorous exercise Exposure to heat Exposure to cold

Anything else that consistently makes you feel better: _____

Anything that consistently makes you feel worse: _____

LIBIDO & INTIMACY

(If you have a partner/spouse) My general feeling toward my partner/spouse is
Loving Affectionate Indifferent Dissatisfied Disappointed Resentment Disgust Hatred

The frequency of my sexual desire or sexual thoughts is (whether you act on this desire or not)
Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week More than once/day

(If sexually active) Approximate frequency of sexual activity
Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week More than once/day