Greg Meyer MD (H) – Meyer Homeopathy LLC

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Registration Form

Name……..

Address……..

Tel. Home……Tel. Cell……Tel. Work…….……..

Email address…….

Date of Birth…….…… Age…….

Marital status: Married ☐ Single ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupations:

……
……
……

Emergency Contact……

Contact for Primary Doctor……...

How did you obtain Dr. Meyer's name for a consultation? .....

……

Have you had any experience with homeopathy in the past? If so what?.....

……
……

Do you see other complementary or alternative therapists (eg. Chiropractor, acupuncturist, naturopath, healer)?

……

Medications – please all drugs (including hormones, sleeping pills, inhalers, creams, lotions, etc.) that you take constantly or intermittently.

Name	Strength/dose	How often

Medications – continued.

Please list all your symptoms/problems below, with the main ones first, providing for each: 1) *the date of onset*, and 2) *an estimate of how severely it troubles you* (10 = worse, 1= very trivial)

	Problem or Symptom	Date of Onset	Severity
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Lifestyle Questionnaire

Alcohol – on how many days of the week do you drink?.....

How much do you consume per day / week?.....

Tobacco – how much do you smoke?.....since what age?.....

If you quit, between what ages did you smoke?.....how much did you smoke?.....

Drugs – do you take any other "recreational" drug, eg. Cannabis, cocaine, ecstasy, meth, etc now or in past?

Which and how often?.....

Exercise – how much do you take and in what form(s)?.....

Relaxation – how much do you take and in what form(s)?.....

Sleep – what time do you normally go to sleep?..... and wake up?.....

Do you have any sleeping difficulties?.....

Occupation, school, college – what hours and days do you normally work in an average week?.....

.....

Are you happy with your work? if not, please detail:.....

.....

Relationships, Do you have any difficult ones?.....

.....

Interests, hobbies & pastimes – what are the main ones.....

.....

Stresses – what are the main ones in your life and how do they affect you?.....

.....

.....

Tiredness, fatigue, lack of energy – do you suffer inappropriately from any of these?.....

If so, give details & since when? .....

.....

Childhood – did you have any particularly stressful or unhappy times? .....

.....

.....

Cravings – please list all foods or drinks that you ever have or have had cravings for. When do they or have they occur(ed)?.....

.....

.....

Aversions – please list everything that you can't stand the taste or smell of .....

.....

Allergies / intolerances / Sensitivities / Adverse Reactions

Do you have or have you in the past had allergies, intolerances, sensitivities or adverse reactions to anything such as foods, additives, drugs, immunizations, fumes, dust, pollens, animals, soaps, detergents, lotions, metals, plants, insect bites, etc? please list:.....

.....

.....

Past medical History

Please list **in order** all problems, diseases, traumas, operations, serious injuries including head injuries, details of mother's pregnancy if known, major life events , (eg. Marriages, separations, divorces, death of loved ones, adoptions, births, etc.)

Year	Age	Event

MAIN COMPLAINT

Please describe your main complaint(s) in as much detail as possible. Note when it started, what makes it better or worse and what treatments you have tried?

Which **vaccinations** have you had? Mark all that apply: Small pox Polio Mumps Measles Chicken pox Tetanus Hepatitis Flu .
Have you had any vaccinations in the last year? Yes No If Yes, describe:

Have you ever had any reactions to any vaccination? Yes No If Yes, describe:

Section C: FAMILY HISTORY Please fill in the details of your family's medical history. If you are adopted and do not know your family's history please indicate so and leave out this section. Please fill in this section as best as you can. Many of you will not know all the details, and that is fine too.

ILLNESS	Self	Father	Mother	Brothers	Sisters	Child#1	Child#2	Child#3	Grandparents
ALLERGIES									
ANEMIA									
ARTHRITIS/GOUT									
ASTHMA									
BLEEDING PROBLEMS									
CANCER									
EPILEPSY									
DIABETES									
ALCHOHOL/DRUGS									
ECZEMA									
EMPHYSEMA									
HEARTH TROUBLE									
HEPATITIS									
HIGH BLOOD PRESSURE									
FREQUENT INFECTIONS									
KIDNEY PROBLEMS									
MENTAL ILLNESS									
MIGRANES									
ABNORMAL PERIODS									
PSORIASIS									
PNEUMONIA									
POLIO									
PROSTATE PROBLEMS									
RHEUMATIC FEVER									
STOMACH PROBLEMS									
STROKE									
THYROID PROBLEMS									
TUBERCULOSIS									
ULCERS									
VENEREAL DISEASE									
WEIGHT PROBLEMS									

Are there any illnesses that run in your family?
Is there any family history of: Tuberculosis Cancer Gonorrhea Scabies

General Symptoms

1) Are you? Thirsty Thirstless Somewhere in between

2) What do you drink?

3) Do you prefer drinks that are? Ice cold Hot drinks Room temperature

4) Is your appetite? Ravenous Average Slightly Increased Decreased

5) Is your body temperature? Too hot Too cold Can't stand heat /cold Not significant

6) What weather are you best in?

7) Is there any weather or time of year that aggravates you?

8) How is your perspiration? Where do you perspire the most, any odor, color, etc?

9) Any problems regarding stools? Any difficulties passing stool, etc

10) How strong is your sexual desire? ……. Do you suffer from any sexual disturbance? ……..
……
WOMEN ONLY: What symptoms do you experience premenstrual or during menstruation? Do you suffer in any way before, during or after menses ?.....
……
11) What is your favorite color(s)?.....

10) Are nightmares a problem for you? Yes No Sometimes

11) Describe any important dreams? Any recurrent dreams now or in the past? ……

……

……

……

……

Circle if you experience any of the following:

headaches
back pains
neck lumps or swelling
loss of balance
dizzy spells
blackouts or fainting
wear glasses
blurry vision
eyesight worsening
seeing double
seeing halos or lights
eye pains or itching
watery eyes
earaches
ear discharge
hearing difficulties
noises in ears
dental problems
sore or bleeding gums
sore tongue
congested nose
runny nose
sneezing spells
head colds
nosebleeds
sore throat
difficulty swallowing
hoarse voice
wheezing or gasping
coughing up phlegm
coughing up blood

chest colds
rapid or skipped heart beats
chest pains
shortness of breath
swollen feet or ankles
armpits or groin swelling
difficulty sleeping
motion sickness
excessive sweating
recurring indigestion
frequent belching
nausea
vomiting
pain in abdomen
bloated abdomen
constipation
loose bowels
black stools
gray or whitish stools
blood with stools
pain in rectum
itching in rectum
frequent urination
involuntary urination
burning on urination
black or bloody urination
weak urine stream
difficulty starting urine
constant urge to urinate
sexual difficulties
change of sexual energy

loss or gain of weight
loss of appetite
always hungry
fatigue or weariness
fever or chills
night sweats
motion sickness
warmer/colder than others
aching muscles or joints
swollen joints
back or shoulder pains
weakness in arms or legs
painful feet
leg cramps
painful feet
trembling
numbness
skin problems
scalp problems
bruise easily
nervousness or anxiety
nervous with strangers
difficulty relaxing
worry a lot
nail biting
difficulty making decisions
lack of confidence
scary dreams or thoughts
shy or sensitive
dislike criticism
angered easily

annoyed by little things
family problems
problems at work (husband's)
lack of concentration
loss of memory
hopeless outlook
feeling of desperation
lonely or depressed
frequent crying
considered suicide

MEN ONLY

penile burning or discharge
swelling on/of testicles
painful testicles

WOMEN ONLY

missed periods
menstrual problems
bleeding between periods
heavy bleeding
bearing down feelings
vaginal discharge
genital irritation
pain on intercourse
swelling of breasts
hot flashes

# of pregnancies
# of births
# of miscarriages
# of premature births
# of caesarean sections
# of abortions

In your own words, describe your personality, both positive and negative aspects. Then, describe in detail any negative attitudes or moods you may experience. What triggers these moods, or attitudes? Whatever describes you, and how you feel about it is important.

What motivates you and what interests you in life? What is important to you?

What would you like to change in yourself and your personality? What do you need to work on in yourself? Where do you feel blocked, tense or disharmonious with yourself or in which area of your life? Sit quietly and feel inside your body – where does it feel tense, knotted or restricted?

Write down any Fears or Worries that you have, including worries about others, shyness, fear of certain animals heights, closed places, crowds, being alone, rejected, public appearance, speeches, thunderstorms, injections, doctors, open spaces……etc.