Homeopathic Health Services, Aaron Means MA– Homeopathic Practitioner
1516 W Lake St, Ste 224, Minneapolis, MN 55408
651-328-4048; homeopathichealthservices.com; homeopathichealth@gmail.com

ADULT INTAKE FORM

Name:_________________________________Birthdate_____________

Home Address:__________________________ H phone_______________

City, State, Zip:__________________________ W Phone:______________

Email _________________________________C Phone_______________

Sex M F Usual Occupation_____________Employer______________
Employment status: ˙school ˙homemaker ˙work ˙full time
˙part time ˙unemployed ˙disabled ˙retired

Referred by_______________________ Angie's List Member? Yes/No
Marital status___________________Number of children_____________

Person to be contacted in case of emergency______________________
Address_______________________________Phone___________

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies); include type of illness, month and year hospitalized, name of hospital, city and state.
#1:____
#2:____
#3:____

Allergies:____
Medications(Type, Dosage, Frequency) ____________________________
____
Medicinal Herbs, Vitamins, Teas:___________________________________

Do you use: ˙Coffee: Amount______ ˙Cigarettes: Amount__________
˙Alcohol: Amount_______ ˙Other drugs: Amount_____________

Year	Tests	Year	Immunizations
_____	˙ Chest x-ray	______	˙Smallpox
_____	˙ Electrocardiogram	______	˙Tetanus
_____	˙TB test	______	˙Polio
_____	˙GI series	______	˙Typhoid
_____	˙Kidney x-ray	______	˙Mumps, Measles
_____	˙Barium Enema	______	˙Flu
_____	˙Other x-rays	______	˙Other

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CHECK for yes <u>only</u> if you have been bothered *<u>recently</u>* by any of these problems.

Y
-- frequent or severe headaches
-- back pains
--neck lumps or swelling
-- loss of balance
-- dizzy spells
-- blackouts/fainting
-- wear glasses
-- blurry vision
-- eyesight worsening
-- see double
-- see halos or lights
-- eye pains or itching
-- watering eyes
--earaches
-- hearing difficulties
-- running ears
-- noises in ears
--dental problems
--sore or bleeding gums
--sore tongue
--congested nose
-- running nose
--sneezing spells
-- head colds

--nosebleeds
--sore throat
--difficulty swallowing
-- hoarse voice
--wheezing or gasping
--frequent coughing
-- cough up phlegm
-- cough 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

Y
-- recurring indigestion
-- frequent belching
-- nausea
-- vomiting
-- pain in abdomen
-- bloated abdomen
-- constipation
-- loose bowels
-- black stools
-- grey or whitish stools
-- pain in rectum
-- itching rectum
-- blood with stools
-- frequent urination
-- involuntary urination
-- burning on urination
-- black or bloody urine
-- weak urine stream
-- diff. starting urine
---constant urge to urinate
-- hopeless outlook
-- difficulty relaxing
-- worry a lot

-- scary dreams or thoughts
--feeling of desperation
-- shy or sensitive
--dislike criticism
--angered easily
--annoyed by little things
--family problems
-- problems at work
--sexual difficulties
-- change of sexual energy
-- considered suicide
-- loss or gain in weight
-- loss of appetite
-- always hungry
-- fatigue or weariness
-- fever or chills
--motion sickness
-- night sweats
- -hot flashes
-- warm/colder than others

Y
--aching muscles or joints
--swollen joints
--back or shoulder pains
-- weakness in arms or legs
-- painful feet
-- trembling
-- numbness
-- leg cramps
-- skin problems
--scalp problems
--itching or burning skin
-- bruise easily
-- nervousness or anxiety
-- nervous with strangers
--nail biting
- --diff. making decisions
-- lack of concentration
-- loss of memory
-- lonely or depressed
-- frequent crying

MEN ONLY
- - burning or discharge
- -swelling on 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
_____#of pregnancies
_____#of births
_____#of miscarriages
_____#of premature births
_____#of caesarean
_____#of abortions

Main Reason for your visit – What is bothering you the most?
____

____

What are you most sensitive to (eg. noise, odors, light, pain)?__________
____
Describe an ideal day in terms of weather and temperature: ___________
____
What are your fears?____
____
____
____
Do you have any hobbies?____
____
(Women only) What premenstrual symptoms do you experience?_______
____
____
Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: ____
____
____
____
____
____
____
How is your energy? Is there any particular time of day when it is lower or higher?____
What environment do you feel most comfort in? (ie desert, mountains, ocean, city)____
How is your sexual interest/drive?_____________________________________
____
What do you most like to eat or crave?________________________________
____
What foods do you most dislike?_______________________________________
____
How is your thirst?____
What temperature do you like fluids?__________________________________
Are there any foods that you are sensitive to or allergic to?____________
____

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Family History: Place an (X) in the appropriate columns for any illnesses that you or your relatives have had.

ILLNESS	self	father	mother	brothers	sisters	Child #1	Child #2	Child #3	grandparent
ALLERGIES									
ANEMIA									
ARTHRITIS/GOUT									
ASTHMA									
BLEEDING PROBS									
CANCER									
EPILEPSY									
DIABETES									
ALCOHOL/DRUGS									
ECZEMA									
EMPHYSEMA									
HEART TROUBLE									
HEPATITIS									
HIGH BLOOD PRESS									
FREQ INFECTIONS									
KIDNEY PROBS									
MENTAL ILLNESS									
MIGRAINES									
ABNORMAL PERIODS									
PSORIASIS									
PNEUMONIA									
POLIO									
PROSTATE PROBLEMS									
RHEUMATIC FEVER									
STOMACH PROBS									
STROKE									
THYROID PROBLEMS									
TUBERCULOSIS									
ULCERS									
VENEREAL DISEASE									
WEIGHT PROBLEMS									