CPH CLIENT HOMEOPATHY QUESTIONNAIRE

NAME	
DATE OF BIRTH / AGE	
ADDRESS	
GP DETAILS	Name: Address Tel

EMAIL:		TELEPHONE:	
How did you hear about us?			

CONSENT TO TREATMENT: I confirm that I request homeopathic treatment. I understand that information pertaining to my case may be used anonymously within a confidential student learning environment as teaching material, and that the homeopath is not asking or encouraging me to terminate any previous therapies, doctors or health professional's treatment that has been instituted. I understand that an illness is not being named or diagnosed and that the homeopath is neither diagnosing nor treating any named disease or diseases forbidden by UK law. CPH handles data to comply with the new **General Data Protection Regulation (GDPR).** The data collect about me covers my name, address, date of birth, contact details and health provided by me. CPH will only use my data for the purpose for which it was collected. CPH does not share any information unless requested by me (e.g. for my GP). A full copy of CPH Privacy Policy can be requested at admin@thecph.co.uk

Only applicable CPH LONDON CLINIC in person patients. Please tick this box if you would like a non-invasive bio-analysis, which will provide an insight into your body biochemistry for your practitioner. There is no additional charge for this service in student clinic.

PRINT NAME:	
SIGNED	
DATE	

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PRESENTING COMPLAINT (S) Please describe below what you would like help with and in priority of significance/urgency. What would you consider to be a positive outcome/ what are your expectations from your treatment?
DATE:

KEY MEASURES	
Height (units):	Weight (units):

MEDICATION TAKEN (Current or Past)			
Medication	**When (age/current?)**	**Indication**	**Side Effects**

HOSPITAL ADMISSIONS			
AGE - date	**Issue**	**Operation**	**Outcome**

VACCINATIONS (Please include all since birth where possible)		
Vaccination	**When**	**After effects**

ALLERGIES & SENSITIVITIES

Allergen (past & present)	Since when	Medication

FAMILY HISTORY: *Please include details of health conditions (current and past), allergies, etc*

Mother:		***Father:***	
Grandmother:		***Grandmother:***	
Grandfather:		***Grandfather:***	
Aunt:		***Aunt:***	
Uncle:		***Uncle:***	
Siblings			
Children			

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MENTAL / EMOTIONAL	
Describe yourself as a person in roughly 10 words	
Fears/Phobias Anxieties	
Irritability/Anger (what makes you angry, how do you manage it/ how quickly does it resolve?) Trouble letting go of past?	
How tearful are you/what causes it, makes it better?	
Sociable/Private/ How do you spend your spare time?	
If you had a week off and money was no object, what would you do?	
Tidy/Messy/OCD	
What is your memory like?	
Childhood (Happy/Sad/ Abuse)	
Views on Money	
Remorse/regrets	
Best thing	
Worst thing	

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PHYSICAL HEALTH *Please try to be as candid as possible as each bit of information helps to identify the perfect remedy match for your person as a whole. The more information I have the better the chance of the remedy taking effect.*		
Please indicate if you experience any of the following	**Tick where appropriate**	**Brief details if relevant**
Structural/Postural pain or discomfort Musculature/ Sitting/Standing/Lying		
Hair/ Scalp (dry, greasy, brittle, texture, flaky, itchy		
Head: Headaches (where on head, how often, when)		
Eyes: Vision/ Infections/ Styes		
Ears: Tinnitus/ Wax / Infections		
Nose/ Sinuses: Hayfever/ PN Drip / Polyps		
Mouth/Tongue/Teeth (infections, ulcers, gums, cold sores)		
Dental Work (fillings, root canals, dentures, implants).		
Neck/Throat/ Infections/ Glands		
Back/Shoulders		
Lungs, breathing problems, infections, mucus		
Chest/Heart/ Breasts		

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Digestive system (acid, dyspepsia, bloat, reflux)		
Liver/ Spleen/ Gallbladder		
Bowels/Colon Rectum (Crohn's, IBS, UC) Anus		
Kidneys/Bladder/ Urination/ Prostate/ Genitals		
Menses/Menarche Menopause/Pill/ Contraception/Birth/ Abortions		
Pregnancy, baby, birthing issues/ breastfed?		
Arms/ Legs/ Hands/Feet		
Skin/Nails (dry, greasy, rash, eruptions, brittle)		
Effects of: Temperature/ Weather/ Perspiration/ Chilliness		
Libido/ STDs		
Sleep/dreams/ position/ snoring/ apnoea		
OTHER		

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LIFESTYLE	
DIET Please describe an average day of food intake	BREAKFAST: LUNCH: DINNER: SNACKS:
Food Desires/Aversions *Please describe any cravings, addictions, habits as well as food you that you would never consider eating, are averse to.*	
Drink/Drugs/Tobacco *Please indicate*	
Exercise: *Daily/weekly – please describe*	
Water intake:	
Energy level: *Please describe or rate out of 10 (where 10 = abundant energy)*	

Please describe anything else that you would like to address/consider during your consultation, or any relevant information you think is important. This may regard specific trauma, event or situation that you think may be contributing to your concerns. (eg car accident, divorce, recurring dreams, etc):