

Questionnaire for the initial Homoeopathic consultation With John Rawlings DIHom PgDSHom HMD FBIH MHMA

Once you have completed the questionnaire in as much detail as possible, please email it to <mailto:info@thenaturalmedicinepractice.com> or send it by post to **The Natural Medicine Practice, 43 Montgomery Street, Hove, Sussex BN3 5BE**

A follow up consultation is usually made three to four weeks later, depending on the problem. If you wish to benefit from the Radionic service, include in a separate envelope a sample of five or more strands of hair from your head.

You may pay online.

1. Personal details

First Name(s) --

Surname --

Address --

Zip or Postcode --

Country --

Email --

Telephone --

Age --

DOB --

Gender --

Marital Status & no. of children --

2. Current symptoms

Describe in your own words, as you experience them, your symptoms.

How long have you had the problem(s)?

Describe any particular important events that have happened in your life recently or a long time ago. How do you feel about these events now?

Describe anything strange or unusual about your current symptoms.

3. General symptoms

Is your body temperature generally cold, average or hot?

Is there a noticeable temperature difference or other sensation in, for example, your feet or hands or other body part?

How are your energy levels during the day, in the morning, midday and evening time?

Which season do you feel best and worst?

How do collars, belts and tight clothing affect you?

Do you have a preference for mountains, woodland, seaside, hot and dry or humid climates?

How do you feel in cold/dry/wet weather?

Does the wind affect you?

Do you mind the sun?

Do you like storms and lightning?

Do you enjoy dancing?

How do you respond to extremes of temperature?

What kind of climate would you choose to spend your vacations?

Do you keep a window open at night or during the day?

How do you feel before/during or after meals?

What foods do you have a strong liking and disliking for?

4. Medical history

How was your birth experience?

Outline your medical history in chronological order starting from as early as you can remember.

List any recurrent health problems.

Describe your family/ ancestral medical history i.e. your mothers and fathers health for example.

Has a diagnosis been made for your condition?

Are you taking any other medication?

5. Questions for women

Do you have any menstrual troubles? Please describe any significant symptoms. Please describe your periods duration, abundance, odour and colour.

Describe your feeling, or behaviour before, during and after your period.

How frequently do your periods come?

Have you ever had, or do you have problems in the area of your reproductive system?

6. About you

What is your eye and hair colour?

What is the condition of your tongue?

Are you average build, thin or overweight?

How would you describe yourself as a person?

How do you think other people see you?

Describe your relationships with any member of your family.

7. Interests and hobbies

Describe any interests/hobbies and how they make you feel.

How do you spend your spare time?

Are there any activities or sports that you do often?

8. Other therapies and self help

What other therapies are you having or have you tried?

Do you take any health food supplements?

What types of activity or practice do you use to improve your health and vitality?

9. Emotional and mental symptoms

When conscious of your emotional and mental states during the day, can you describe what is predominant?

Do you dream at night? If so, what are your dreams and do they recur?

What were your deepest griefs in your life?

How do you cope with worries, concerns, problems?

Which or what kind of activity brings peace to your state of mind and emotions?

Can and do you cry?

What effect does consolation have on you?

Do you ever feel jealous?

Do you ever feel frightened or anxious?

How is your memory, understanding and concentration?

10. Concluding questions

Do you smoke or drink alcohol?

Do you take any unprescribed drugs?

Do you have any skin problems, or have you had them in the past. If so, describe them and how they were treated. Please describe any other problems with any body part or function.

How is your vision, hearing and smell?

Do you have, or have you ever had, any dental problems?

Is there anything else that you feel would be worth mentioning?

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