Homoeopathy is a unique system of treating both physical ailments and emotionally based problems.

Appropriate treatment for you requires knowledge of your background and present characteristics in as much detail as possible.
This is because Homoeopathic treatment is prescribed for the individual person, not just the disease. For example, several people seeking help for the same complaint would often be given different remedies because their individual symptoms and characteristics differ. The remedy is matched with your total physical, mental and emotional picture.

Detailed information is vital to effective prescribing. You are asked to write a "life picture" to assist your practitioner in helping you This may take time and effort. Complete information will make the remedy selection more accurate. Your life picture will be considered together with the data from your consultation. All the information will be treated as confidential. Where possible please provide the statement in your own handwriting and follow the guidelines set out within.
When you have finished, post or deliver your paper immediately so it may be studied before your next visit.

1. IDENTITY & ENVIRONMENT

Begin by setting out the following:

Full name, address and phone numbers, Date and place of birth. Marital status. Religion. Domestic situation, i.e. living alone, with family, communal household, in relationship etc.

Now describe the following:

Occupation (paid and unpaid): Current and previous; with a full description of the responsibilities and degree of job satisfaction, and general work environment - pressures, conflicts etc. Include reasons for any job changes.

Education history & qualifications

Current family situation: Details of all members, their ages, location, occupation, your responsibility to them, and any family difficulties.

Your daily routine: including bowels and bladder function etc. Record details of your average days diet including snacks.

Financial responsibilities and strains (present as well as past)

2. MAIN COMPLAINTS

Describe fully what bothers you the most, using the following format:

Give a complete picture of the trouble right from the time of onset. Include:

i/ Area affected at first, the subsequent development and spread of the problem and the response to previous treatments, if any.
ii/ Sensations experienced in the area of trouble.
iii/ Conditions that have brought on the trouble. Examine the circumstances just before or at time of onset, paying attention to physical as well as emotional factors.
iv/ Conditions or actions that increase or relieve the problem
v/ Other troubles experienced at the same time.

3. OTHER COMPLAINTS

Describe here all other troubles. Each should be described fully as suggested above.

4. PERSONAL DATA

Give a full account of the following:
i/ Birth: Give any available details of your birth, infancy and severity eg colic etc.
ii/ Childhood development: Age, progress & difficulties of teething, crawling, walking, talking.
iii/ Physical description of yourself (height, weight, build, complexion)
iv/ Emotional and intellectual nature.

Use the following guidelines if you wish.

a/ Studies past & present. Indicate general performance. Concentration, memory, communication. Aims for the future. Your outlook on life. Hopes aspirations, ambitions & extent to which you have fulfilled them. Self image and self confidence.

b/ Give a clear cut picture of your relationship with each family member. How do you get on with your friends and associates? Are there any changes you would like to make in your emotional self or in relationships? Any particular social difficulties. Preference for company or solitude?

c/ Past and present stressful situations & how these affected you. Responsibilities in your life and how you feel about them. Emotional situations and how you react. Physical symptoms which occur following emotional states.

d/ Affinities to countries, cultures, environments. Interests, hobbies, skills.

v/ Food. Desires & aversions, foods that you cant do without or that disagree. Appetite, thirst. Consumption of alcohol, tobacco, tea, coffee, medications & drugs.

vi/ Describe your reactions to weather, temperature, moon phases, and general environment. etc.

vii/ Environmental health hazards: Work & other.

viii/ a/ Sleep: Any problems experienced

b/ Dreams: Recurring themes, nightmares

x/ Reproductive system.

a/ Sexual function & any difficulties

b/ Menstrual history. Age of onset, length of cycle & flow. Problems. Menopause.

c/ Obstetric history. Details of each pregnancy (including cravings and aversions, general health, and state of mind). Labour and post-natal period.

Previous Illnesses

Starting from childhood list the illnesses, complaints, surgery & vaccinations you have had. Give details of reactions experienced, rate of recovery and to what extent these have a bearing on the present troubles.

Family Medical History

List health problems that have afflicted your grandparents, parents, brothers, sisters, include any details of any who have died, stating their age, cause of death and how you were at the time. Give details of the health of your wife/husband/partner and children. Do any diseases run in your family?

Other Details

Include anything you feel may be important which is not already covered.

Enclosures **Provide** copies of any medical reports, test results, X-rays, etc. if available.

Thankyou for your co-operation. If you have any queries please ring

Pauline Ashford

B. Health Science – Complementary Medicine - Homoeopathy

130 Ansell Rd., (Off cnr of Witta Sportsground)

Witta via Maleny Q 4552 Ph 54944101

Email: paulineashford@optusnet.com.au

Clinic days Mon 12-9pm, Tues 9-5

Thurs 9-5 Other days by appt only

Patient History for Homoeopathic Treatment

Guidelines for writing your medical & personal history.
'a life picture'