



*Rebecca Liston*  
H.D., DSHomMed  
Homeopathic Physician

## *Pre-Consultation Questionnaire*

In order to determine the proper Homeopathic remedy for you, together we need to investigate and evaluate all of the subjective and objective symptoms that you are experiencing within the context of your individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent together in consultation most effective, I request that you complete the following information form as in-depth and accurately as possible, and that you bring this form along with you to our first consultation.

If you have any questions, please feel free to contact me. Please also remember that any and all information that you provide is kept in the strictest confidence according to the laws of Homeopath-Patient confidentiality.

*Thank you and I look forward to meeting with you!*

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_

Email \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Would you like to be on our mailing list? Circle: YES NO

Family Doctor's name and phone number  
\_\_\_\_\_

Referred by \_\_\_\_\_

Medical complaints: please list your major medical complaints in order of importance to you  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## *Medical History*

**Vaccination History:** *please circle all vaccinations that you have had:*

Tetanus/Diphtheria/Polio ("DPT")      Hepatitis      Measles/Mumps/Rubella ("MMR")      Chicken Pox  
Whooping Cough      Influenza      Other: \_\_\_\_\_

**Medical Conditions:** *please circle all conditions that you have had in the past or that you currently have:*

Abscesses	Anemia	Allergies	Arthritis	Asthma	Cancer
Chicken Pox	Cold Sores	Depression	Drug Abuse	Diabetes	Eczema
Emphysema	Epilepsy	Frequent Colds	Gallstones	Gout	Heart Disease
Hepatitis	HIV	Influenza	Kidney Disease	Leukemia	Lyme Disease
Malaria	Measles	Mononucleosis	Multiple Sclerosis	Mumps	Parasites
Pelvic Inflammatory Disease		Endometriosis	Anxiety	Polycystic Ovary Syndrome	
Infertility	Peritonitis	Pneumonia	Prostatitis	Psoriasis	Rheumatic Fever
Rubella	Scarlet Fever	Warts	Venereal Warts	Herpes Genitalia	Skin Diseases
Sinusitis	Polyps	Strep Throat	Stroke	Sunstroke	Urinary Tract Infection
Tonsillitis	Tuberculosis	Typhoid Fever	Whooping Cough	Yellow Fever	Intestinal Worms
Ulcers	Fibromyalgia	Chronic Fatigue Syndrome		Migraines	Cirrhosis
Alcoholism	Miscarriage	Premenstrual Syndrome		High Blood Pressure	Low Blood Pressure
Colitis	Crohn's Disease	Goitre	Hyperthyroidism	Hypothyroidism	Gonorrhoea
Syphilis	Acne	Pleurisy	Postmenopausal Symptoms		Elevated Cholesterol

Other: \_\_\_\_\_

**Medications:** *please list all medications that you currently take or have taken in the last year:*

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# Medical History

**Complementary Medicine:** *please list any alternative therapies that you are currently undergoing or have undergone in the past year (e.g. aromatherapy, acupuncture)*

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**Nutritional Supplements:** *please list any vitamins, herbs, supplements that you currently take*

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**Surgeries and Major Injuries:** *please list any surgeries you have undergone or any major injuries you have suffered*

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**Family History:** *please circle all that apply*

Alcoholism      Cancer      Depression      Heart Disease      Gonorrhea      Syphilis  
Malaria    Alzheimer's Disease      Diabetes      Stroke      Anxiety      Dementia  
Migraines      Other: \_\_\_\_\_