Questionnaire

SULIS HOMEOPATHY INC.
310-986-1000
8632 S. Sepulveda Blvd, Suite 200
Los Angeles, CA 90045

First Name:_____ **Last Name**_____

Address_____ #_____City_____

State_____Zip Code_____ Email_____

Cell phone_____ Home/work phone_____

Facebook_____ Instagram_____

What is your main complaint/complaints?_____

If homeopathy could help you with anything ,what else would you like to see improve?

What is different, peculiar, or unusual about your symptoms?_____

Are there certain days, times of day, kind of weather or anything that makes you feel better or worse?

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1. Height _____
2. Weight_____
3. Age _____DOB_____
4. Female _____Male-_____
5. Marital Status_____
6. Occupation_____
7. What do you like about your work?_____

_____

Dislike?_____

_____

8. Do you work with chemicals or any hazardous materials?
   a) No
   b) Yes What? _____

_____

9. Do you have allergies? Please list:
   a) _____
   b) _____
   c) _____
   d) _____
   e) _____
10. What stomach or digestive issues do you have?
    a) constipation
    b) diarrhea
    c) IBS
    d) nausea
    e) vomiting
    f) hemorrhoids
    g) other_____
11. What foods or drinks bother you?
    a) _____
    b) _____
    c) _____
    d) _____
12. What food or drink do you crave or enjoy most?
    a) _____
    b) _____
    c) _____
    d) _____
13. Do you drink alcohol?
    a) Yes
    b) No
    c) How much?_____
14. Do you use recreational drugs?
    a) Yes What?_____
    b) No
15. Do you smoke?
    a) Yes_____How much?_____
    b) No
    c) Quit_____When?_____
16. What respiratory issues do you have?
    a) asthma
    b) sinusitis
    c) shortness of breathe
    d) pneumonia/bronchitis
    e) COPD
    f) cough_____
    g) other_____

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17. What back/neck problems do you have?____

18. Do you have any problems with your:
    a) arms, shoulders, elbows
    b) hands, fingers, fingernails
    c) legs, feet, knees, toenails
    d) Explain_____

19. What problems do you have with your skin?

20. Urinary Problems:
    a) UTI/cystitis
    b) incontinence
    c) waking frequently to urinate
    d) enlarged prostate
    e) _____

21. How is your sleep?
    a) good
    b) fair
    c) poor
    d) explain:_____

22. Do you dream now? yes no

23. What dreams do you remember?_____

24. What do you fear or worry about most?

25. What illnesses are common in your family?
    a) _____
    b) _____
    c) _____
    d) _____
    e) _____

26. Circle all that apply to you past or present:
    a) abuse: mental, emotional, physical, sexual
    b) panic attacks
    c) anger/ rage/ irritable
    d) poor memory/ mental fog
    e) sadness/depression
    f) hyperactive/restlessness/ ADD, ADHD
    g) nervous/ anxious/ worry
    h) compulsive behavior/ OCD
    i) bipolar/ mood swings
    j) low self esteem
    k) hoarding or difficulty getting rid of stuff
    l) perfectionist/ controlling
    m)learning disabilities/ poor concentration
    n) guilt/ shame/ embarrassment
    o) shy/ isolation/ worry what others think

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MEDICATIONS/HERBS	REASON FOR TAKING THIS MEDICINE

LIST ALL SURGERIES YOU HAVE HAD	DATE OF SURGERY

Have you ever had an STD? a) Yes b) No What?_____

Which best describes your libido (sex drive)? a) High b) Low c) Average d) Not an issue

ANY ADDITIONAL INFORMATION:_____

NEAREST RELATIVE_____Phone_____

Your signature_____Date_____