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MIGHTY OAKS THERAPIES:
17774 Cypress Rose Hill Suite 320
Cypress, TX 77429
C: +1 (832) 792-9399
E: stacyc@mightyoakstherapies.com
W: mightyoakstherapies.com

CLIENT QUESTIONNAIRE (18+)

1. PERSONAL INFO

Name: _____

Date of Birth: _____ Initial Appointment Date: _____

2. MEDICAL HISTORY

What is the client's main concerns or complaints?

Has the client received formal homeopathic consultation prior to this visit? If so, list their name:

☐ Yes _____ ☐ No

To which two remedies have you responded best?

Remedy	Frequency	Potency

Has the client been hospitalized? ☐ Yes ☐ No

Reasons for hospitalization	Date

Detail any important medical diagnoses or conditions, include significant events such as any adverse medication reactions, adverse vaccine events, etc.:

Please include dates of diagnosis or age when diagnosed, as appropriate

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2. MEDICAL HISTORY

What worsens your conditions (i.e.: winter, motion)?

Improves (i.e.: pressure, better morning, etc.)?

List any allergies or food intolerances:

Allergies	Food Intolerances	Reaction (ex: hives, throat closes,etc)

List medication, remedies, vitamins, supplements and frequency taken:

Name	Dose	Name	Dose

Do you take antibiotics frequently? ☐ No

☒ Yes, How often? _____

List frequently consumed foods (i.e.: drinks milk daily, only eats meat/bread, craves pickles, etc):

List any traumas you've experienced or affected your life (i.e.: car accident, divorce)

List specific dates and then outline details as necessary

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4. FAMILY MEDICAL HISTORY

Check any that apply		Please list family member to which it applies: self, paternal grandfather, mother, etc...
Alcoholism/Drug	☐	
Abuse	☐	
Asthma	☐	
Cancer	☐	
Depression/Anxiety/Bipolar	☐	
Diabetes	☐	
Emphysema (COPD)	☐	
Heart Disease	☐	
High Blood Pressure	☐	
High Cholesterol	☐	
Thyroid Disease	☐	
Renal (kidney) Disease	☐	
Migraine Headaches	☐	
Stroke	☐	

Please use the space below to express any other concerns you would like your homeopath to know: