Dr. Susan Seven-Sky
263 Columbus Avenue
West Harrison, NY 10604
914-305-4254
914-949-0405 (FAX)

Homeopathic Symptom Questionnaire

Please answer the following questions using the simplest and most descriptive language. Consider each question carefully and do not leave anything out no matter how remote it may appear from your presenting complaint. If you are a health professional, avoid using clinical terminology. On this form, it is not necessary to repeat any statements of previous doctors or treatments.

Simply describing what you feel, think and observe without providing an explanation for them is the best way to report your symptoms. The most usable symptoms for proper treatment are those considered to be unique and specific to you as a person. Also of importance are the peculiar and characteristic symptomatic events that have taken place during your ailment.

Use a separate piece of paper to answer the questions and please be reminded that this information is part of your medical records regarded with the utmost confidentiality.

1. What complaints and symptoms bring you to me and what have you done about them until now?
2. At what time of 24-hour day or night or at what hour do you feel worse?
3. At what time of year do you feel worse?
4. When do you feel the best (symptom-free)?
5. How does cold weather affect you? Hot weather? Dry weather? Damp weather?
6. How does sunlight affect you?
7. How are you affected by changes in weather?
8. Some people are always freezing and feel the cold; others always feel warm or too hot. To which group do you belong?
9. Ho do you feel before, during or after a storm?
10. How do you keep your window at night?
11. How does warmth in general affect you? The warmth of the bed? The warmth of a room?
12. How do you react to extreme temperatures (very hot or very cold)?
13. How often do you catch colds in winter? At other times of the year?
14. How do you feel spending all day indoors?
15. What positions are uncomfortable for you? Which are comfortable? Sitting, standing, lying down? Why?

16. What about car sickness or any type of motion sickness?
17. How do you feel if you miss a meal?
18. How is your appetite? At what times do you feel hungry?
19. What do you like to drink with your meals and how much do you drink at each meal?
20. Are you very thirsty or have little thirst?
21. What foods and drinks disagree with you and why?
22. How are you affected by wine, beer, coffee, tea, milk, vinegar?
23. Do you smoke? How much/day?
24. How are you affected by:
    - Sweets
    - Salt
    - Sour
    - Greasy
    - Eggs
    - Meat
    - Pork
    - Bread
    - Butter
    - Onions
    - Fruit
    - Ice Cream
25. Are there any drugs that make you sensitive or sick?
26. In what circumstances have you felt like fainting?
27. What vaccinations and inoculations have you had and what were their affects on your health?
28. How do you react to a hot bath? Cold bath? Swimming in the ocean?
29. How do you feel when your collar is buttoned? Do you like a belt around your waist? How do you feel in tight-fitting clothes?
30. How do your wounds heal? How long do you bleed?
31. How do you like being alone? How do you like being around other people? On what occasions do you weep?
32. How do you like being consoled by someone you like?
33. In what situations do you feel jealous?
34. What are the greatest joys of your life?

35. What sort of fears do you have? Are you afraid of?
    - Water
    - Animals
    - Before or during thunderstorms
    - Burglars
    - Falling
    - Being alone
    - That you will lose your mind
    - The dark
    - The future
    - Getting sick
    - Other
36. What are the greatest grieves you've gone through in your life? How did you handle it?
37. How do you feel in a crowd?
38. Under what circumstances do you get angry? What makes you angry?
39. What time of day in 24 hours do you feel blue, sad, depressed?
40. When do you have thoughts of death and suicide?
41. In times of depression, how do you view death?
42. How do you handle worries?
43. What foods or drinks do you have a craving?
    - Candy
    - Pastry
    - Sweetened foods
    - Sour things
    - Spicy things
    - Heavy fatty foods
    - Butter
    - Bread
    - Fruit
    - Fish
    - Meat
    - Coffee
    - Wine
    - Beer
    - Salt
    - Other
44. What foods or drinks do you dislike very much?
45. What foods or drinks make you sick or disagree with you?
46. In what position do you like to sleep? How do you put your arms, your legs, and your head? Many people like their head low, while others like it somewhat raised – how about you?
47. Some people talk, scream, cry or laugh in their sleep. They suddenly wake up scared, are restless, are afraid, grind their teeth in their sleep, sleep with their eyes open or with their mouth open. How about you?
48. Are you restless during sleep?

49. What time do you wake up? What time do you get out of bed?
50. What times during the night can't you sleep? When, during the day, are you sleepy? Why are you sleepy then?
51. Do you have any recurring dreams? Please describe.
52. How old were you when your periods began? How often does it come now? How much? How regular is your period? How long does it last? What color is it? How does it look? How does the blood look? Tell me the time of day or night when it flows the most? How do you feel before, during and after your period, physically and emotionally?
53. What is the history of nervous and mental illness and serous diseases, such as tuberculosis, rheumatism, cancer, etc. in your family?
54. Tell me in detail what you eat and drink at your meals.
55. What time do you go to bed? Tell me in detail about your daily schedule, about your activities, your rest periods, your entertainment and your relaxation?
56. What about your weight?
57. Tell me about any complaints you have that have not come up in these questions.
58. On what occasions have you felt frightened or anxious?
59. What affects have you had, if any, to grief, disappointed love, anger, indignation, mortification, fright or bad news.
60. Tell me about:
    - Over-conscientiousness
    - Over-scrupulousness
    - Attention to details – a little or a lot
    - Having things in order