



Virginia A. Oram, N.D.  
Naturopathic Physician

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358 Blair Boulevard

Eugene, Oregon 97402

[www.DrOram.com](http://www.DrOram.com)

Dear

We want to take this opportunity to welcome you! We are honored that you have decided to work with us in your efforts to obtain optimum health.

Our practice is committed to quality, competent, and compassionate Naturopathic healthcare. We provide all phases of primary health care, blending centuries-old knowledge of natural non-toxic therapies with current advances in the understanding of health and human systems. The full range of services provided includes:

- Family health care including physical exams and laboratory analysis for all family members from young to old, male and female
- Full women's health services including annual exams and PAPs
- Full pediatric care, including advice about immunizations
- Individualized metabolic detoxification programs
- Physical medicine: Ortho-Bionomy, Maya Abdominal Therapy, spinal manipulation and electrical stimulation
- Specialty treatments: Heavy metal detoxification, chemical sensitivity treatment, allergy testing, etc.

We have reserved a First Office Call appointment for you on \_\_\_\_\_ at \_\_\_\_\_ am/pm. Our office staff extends the courtesy of a reminder call one business day prior to your appointment when we are able to reach you at the number that you have designated. At least 48 business hours notice is required in the event that you need to cancel or reschedule your appointment. Cancellations without 48 business hours prior notice will be charged for half of the cost of the visit, cancellations with out prior notice will be charged the full fee. For further information on policies and fee schedules, please see the enclosed paperwork.

We are located at 358 Blair Boulevard in Eugene. Our office is across from the Red Barn Natural Grocery. The clinic is in a green two-story renovated home with a white picket fence. You may park your car in our front or rear parking lot (recommended).

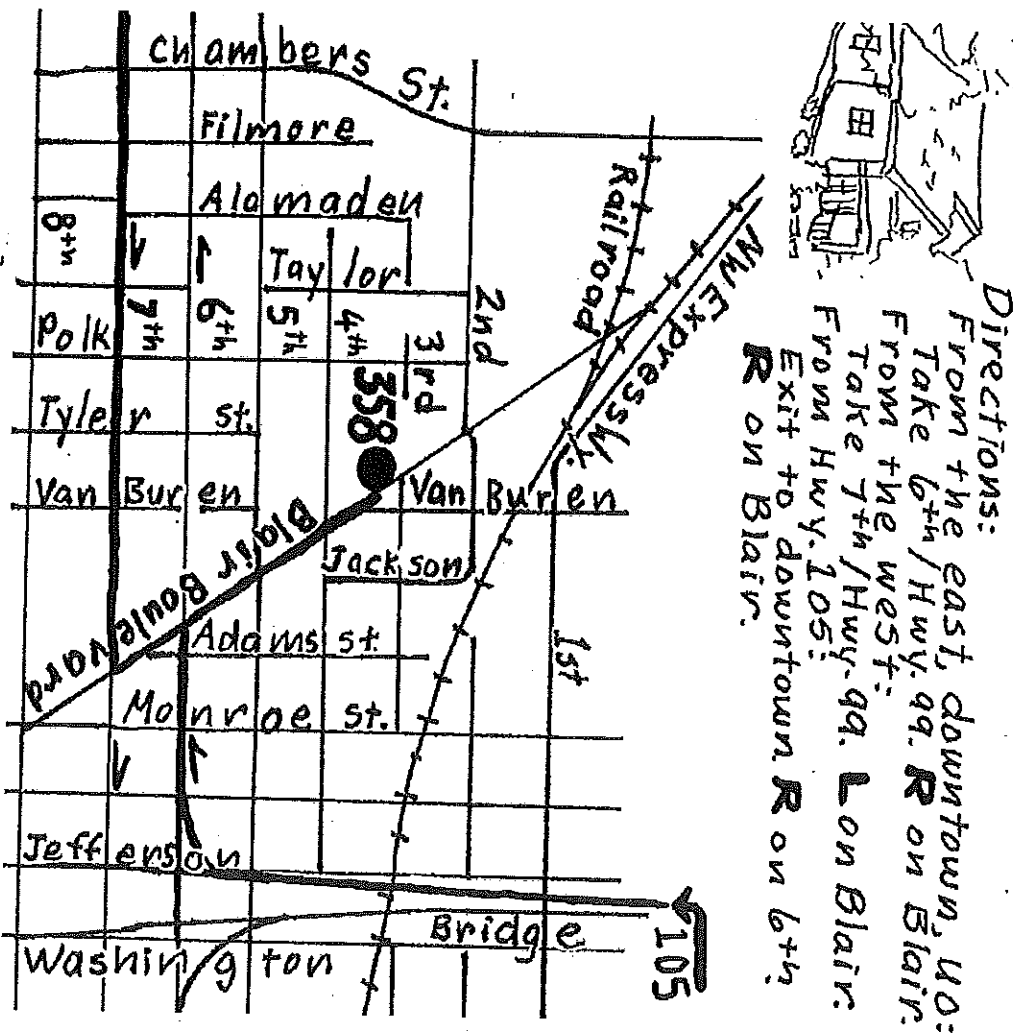
Please don't hesitate to call should you have any questions prior to your appointment. We look forward to meeting you.

Sincerely,

Virginia A. Oram, ND  
and Staff

Vibrant Health is a Natural Path Away!

**Dr. Oram**  
 Blair Centre for Natural Medicine  
 358 Blair Boulevard  
 Eugene, OR 97402



Illustrated and designed by Tyler Burgess.

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### Our office is a FRAGRANCE-FREE ZONE

In response to health concerns we have developed a scent-free policy. Scented products such as soaps, lotions, hairsprays, deodorants, perfumes, incense, essential oils, patchouli, musks, etc. can trigger reactions such as respiratory distress and headaches.

Staff and visitors are asked not to use any fragrances when in our office.

Thank you for your consideration of others.

Sincerely, Dr. Oram & Staff

# PATIENT REGISTRATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Occupation \_\_\_\_\_ Full or Part Time \_\_\_\_\_ Retired \_\_\_\_\_

Employer (Name & Address) \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Education \_\_\_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Cohabiting \_\_\_\_\_

If patient is a child, please indicate the following:

Mother's name \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Child lives with you? \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Child lives with you? \_\_\_\_\_

Are there other co-parents? \_\_\_\_\_

Name and Address of Relative or Friend in case of Emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_

Name of Family Doctor, if any \_\_\_\_\_

## FAMILY HISTORY

Has any blood relative had any of the following? If so, please indicate their relationship to you and name the disease on the lines provided below:

Anemia	Eczema	Epilepsy	Stomach/Duodenal ulcer
Bleeding easily	Arthritis/Rheumatism	High blood pressure	Tuberculosis
Genetic disease	Cancer/Tumor	Heart disease	Alcoholism/Drug addiction
Allergies/Asthma	Diabetes	Stroke	Nervous breakdown
Hay fever	Glaucoma	Thyroid trouble	Suicide
		Venereal disease	Other

## YOUR HEALTH HISTORY

Have you ever had any of the following? If so, indicate how old you were, in the blank next to the specific condition:

\_\_\_\_\_ Cancer \_\_\_\_\_ Herpes \_\_\_\_\_ Syphilis \_\_\_\_\_ Bad reaction to an immunization

\_\_\_\_\_ Tuberculosis \_\_\_\_\_ Gonorrhea \_\_\_\_\_ Other serious illness/injury \_\_\_\_\_

Have you ever had surgery or been hospitalized? If so, please indicate when and for what reason: (Do not include normal pregnancies) \_\_\_\_\_

Are you allergic to any medicines or other substances? If so, please indicate: \_\_\_\_\_

What medicines do you presently take, including supplements and nonprescription items? \_\_\_\_\_

PAYMENT IS EXPECTED AT THE TIME OF SERVICES. THANK YOU.

**INSURANCE INFORMATION:** If you have **NO** insurance, check here \_\_\_\_\_

**PRIMARY INSURANCE** (which co. we should bill first):

Subscriber's name (person's name the insurance is under) \_\_\_\_\_

Subscriber's address (if different than patient's) \_\_\_\_\_

Subscriber's Date of birth \_\_\_\_\_ Subscriber's employer \_\_\_\_\_

Address of Insurance Co. \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is there a second insurance company? \_\_\_\_\_

Subscriber's name \_\_\_\_\_

Subscriber's date of birth \_\_\_\_\_

Subscriber's employer \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

If someone other than the **PATIENT** is responsible for payment, complete the following:

Name of responsible party \_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (if different than patient's) \_\_\_\_\_

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

**Please sign and return to receptionist.**

I hereby authorize your office to release any medical records or other information necessary to secure medical benefits.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all expenses, including reasonable attorney fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## How Do I check my Insurance Benefits?

Patient Name \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Our office will happily bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-7 when calling to find out your benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid through?  
Beginning Date of Coverage \_\_\_\_\_ End Date of Coverage \_\_\_\_\_

2. Do I need a referral from my primary care physician (PCP) for alternative services?  
Yes \_\_\_\_\_ No \_\_\_\_\_

3. Is the doctor I want to see (Virginia Oram, ND) In-Network or a Preferred Provider with my insurance?  
Yes \_\_\_\_\_ No \_\_\_\_\_

4. What are my benefits for the following services? *\*Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*

Naturopathic: % Covered \_\_\_\_\_; Co-pay/Co-Insurance \_\_\_\_\_; Year Max \_\_\_\_\_

Labs: % Covered \_\_\_\_\_; Co-pay/Co-Insurance \_\_\_\_\_; Year Max \_\_\_\_\_

5. Do charges for Labs come out of Year Max for Naturopathic services:  
Yes \_\_\_\_\_ No \_\_\_\_\_

6. Is there a Co-pay per visit or per specialty? Circle one.

7. What is my deductible for the year and has any or all of it been met?

Deductible: \$ \_\_\_\_\_ Amount of Deductible met so far: \$ \_\_\_\_\_ Date \_\_\_\_\_

Are any of the services listed above subject to this deductible? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, which services? \_\_\_\_\_

7. What was the name of the representative you spoke with? \_\_\_\_\_  
Date \_\_\_\_\_

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

*\*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.*

## Consent to Treatment with Dr. Virginia A. Oram

Patient's Name: \_\_\_\_\_

Please Print

First

Middle

Last

- I. This is to acknowledge that I have been informed and understand that:
- i) Any treatment or advice provided to me, as a patient of Dr. Virginia A. Oram is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
  - ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.
  - iii) No physician, employee, or anyone else under the direction or control of the clinic is recommending that I refrain from seeking or following the advice of another licensed health care provider.
  - iv) The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider.
- II. I agree to pay for any fees for service, costs of supplements and remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan.
- III. I hereby authorize and consent to treatment.

\_\_\_\_\_  
Patient Signature

Date: \_\_\_\_\_

# HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date: \_\_\_\_\_ Patient # \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

History of present illness:

Location: \_\_\_\_\_  
(Where is the pain/problem?)

Quality: \_\_\_\_\_  
(Example: normal versus abnormal color, activity, etc.)

Severity: \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: \_\_\_\_\_  
(How long have you had this pain/problem?, or, When did it start?)

Timing: \_\_\_\_\_  
(Does the pain/problem occur at a specific time?)

Context: \_\_\_\_\_  
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms \_\_\_\_\_  
(What other associated problems have you been having?)

Modifying factors \_\_\_\_\_  
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

## Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles .....	no	yes	Anemia .....	no	yes	Back trouble .....	no	yes	Hepatitis .....	no	yes
Mumps .....	no	yes	Bladder Infections .....	no	yes	High Blood Pressure .....	no	yes	Ulcer .....	no	yes
Chickenpox .....	no	yes	Epilepsy .....	no	yes	Low Blood Pressure .....	no	yes	Kidney Disease .....	no	yes
Whooping Cough .....	no	yes	Migraine Headaches .....	no	yes	Hemorrhoids .....	no	yes	Thyroid Disease .....	no	yes
Scarlet Fever .....	no	yes	Tuberculosis .....	no	yes	Date of last chest x-ray .....			Bleeding Tendency .....	no	yes
Diphtheria .....	no	yes	Diabetes .....	no	yes	Asthma .....	no	yes	Any other disease .....	no	yes
Smallpox .....	no	yes	Cancer .....	no	yes	Hives or Eczema .....	no	yes	(please list):		
Pneumonia .....	no	yes	Polio .....	no	yes	AIDS or HIV+ .....	no	yes			
Rheumatic Fever .....	no	yes	Glaucoma .....	no	yes	Infectious Mono .....	no	yes			
Heart Disease .....	no	yes	Hernia .....	no	yes	Bronchitis .....	no	yes			
Arthritis .....	no	yes	Blood or Plasma Transfusions .....	no	yes	Mitral Valve Prolapse .....	no	yes			
Venereal Disease .....	no	yes				Stroke .....	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: (Include nonprescription)

\_\_\_\_\_  
\_\_\_\_\_

## Patient social history:

Marital status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_  
 Use of tobacco: Never: \_\_\_\_\_ Previously, but quit: \_\_\_\_\_ Current packs / day: \_\_\_\_\_  
 Use of drugs: Never: \_\_\_\_\_ Type/Frequency: \_\_\_\_\_  
 Excessive exposure at home or work to: Fumes: \_\_\_\_\_ Dust: \_\_\_\_\_ Solvents: \_\_\_\_\_ Air-borne Particles: \_\_\_\_\_ Noise: \_\_\_\_\_

## Family medical history:

Age	Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

**Review of Systems: Please indicate any personal history below:**

☐ **Constitutional Symptoms**

Good general health lately . . . . No Yes  
Recent weight change . . . . No Yes  
Fever . . . . No Yes  
Fatigue . . . . No Yes  
Headaches . . . . No Yes

☐ **Eyes**

Eye disease or injury . . . . No Yes  
Wear glasses/contact lenses . . . No Yes  
Blurred or double vision . . . . No Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing . . . . No Yes  
Earaches or drainage . . . . No Yes  
Chronic sinus problem or rhinitis . No Yes  
Nose bleeds . . . . No Yes  
Mouth sores . . . . No Yes  
Bleeding gums . . . . No Yes  
Bad breath or bad taste . . . . No Yes  
Sore throat or voice change . . . No Yes  
Swollen glands in neck . . . . No Yes

☐ **Cardiovascular**

Heart trouble . . . . No Yes  
Chest pain or angina pectoris . . No Yes  
Palpitation . . . . No Yes  
Shortness of breath w/walking  
or lying flat . . . . No Yes  
Swelling of feet, ankles or hands. No Yes

☐ **Respiratory**

Chronic or frequent coughs . . . No Yes  
Spitting up blood . . . . No Yes  
Shortness of breath . . . . No Yes  
Wheezing . . . . No Yes

☐ **Gastrointestinal**

Loss of appetite . . . . No Yes  
Change in bowel movements . . . No Yes  
Nausea or vomiting . . . . No Yes  
Frequent diarrhea . . . . No Yes  
Painful bowel movements  
or constipation . . . . No Yes  
Rectal bleeding or blood in stool No Yes  
Abdominal pain . . . . No Yes

☐ **Genitourinary**

Frequent urination . . . . No Yes  
Burning or painful urination . . . No Yes  
Blood in urine . . . . No Yes  
Change in force of strain  
when urinating . . . . No Yes  
Incontinence or dribbling . . . . No Yes  
Kidney stones . . . . No Yes  
Sexual difficulty . . . . No Yes  
Male - testicle pain . . . . No Yes  
Female - pain with periods . . . No Yes  
Female - irregular periods . . . No Yes  
Female - vaginal discharge . . . No Yes  
Female - # of pregnancies . . .  
Female - # of miscarriages . . .  
Female - date of last pap smear

☐ **Musculoskeletal**

Joint pain . . . . No Yes  
Joint stiffness or swelling . . . . No Yes  
Weakness of muscles or joints . . No Yes  
Muscle pain or cramps . . . . No Yes  
Back pain . . . . No Yes  
Cold extremities . . . . No Yes  
Difficulty in walking . . . . No Yes

☐ **Integumentary (skin, breast)**

Rash or itching . . . . No Yes  
Change in skin color . . . . No Yes  
Change in hair or nails . . . . No Yes  
Varicose veins . . . . No Yes  
Breast pain . . . . No Yes  
Breast lump . . . . No Yes  
Breast discharge . . . . No Yes

☐ **Neurological**

Frequent or recurring headaches No Yes  
Light headed or dizzy . . . . No Yes  
Convulsions or seizures . . . . No Yes  
Numbness or tingling sensations No Yes  
Tremors . . . . No Yes  
Paralysis . . . . No Yes  
Head injury . . . . No Yes

☐ **Psychiatric**

Memory loss or confusion . . . . No Yes  
Nervousness . . . . No Yes  
Depression . . . . No Yes  
Insomnia . . . . No Yes

☐ **Endocrine**

Glandular or hormone problem . No Yes  
Excessive thirst or urination . . . No Yes  
Heat or cold intolerance . . . . No Yes  
Skin becoming dryer . . . . No Yes  
Change in hat or glove size . . . No Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts . . . . No Yes  
Bleeding or bruising tendency . . No Yes  
Anemia . . . . No Yes  
Phlebitis . . . . No Yes  
Past transfusion . . . . No Yes  
Enlarged glands . . . . No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse  
reaction to:  
Penicillin or other antibiotics . . No Yes  
Morphine, Demerol,  
or other narcotics . . . . No Yes  
Novocain or other anesthetics . . No Yes  
Aspirin or other pain remedies . No Yes  
Tetanus antitoxin  
or other serums . . . . No Yes  
Iodine, Merthiolate or  
other antiseptic . . . . No Yes  
Other drugs/medications: \_\_\_\_\_

Known food allergies: \_\_\_\_\_

Environmental allergies: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Review

Signature of Doctor \_\_\_\_\_

Date \_\_\_\_\_



## PREPARING FOR YOUR HOMEOPATHIC CONSULTATION

This handout has been prepared to help you participate effectively in your homeopathic treatment. It contains instructions for preparing for your homeopathic consultation, and practical information about the course of treatment. Please read this material carefully and keep it to re-read occasionally, especially if you have not been in for some time.

### THE HOMEOPATHIC CONSULTATION FOR CHRONIC DISEASE

The information that you provide the physician is *essential* for effective homeopathic treatment. The homeopathic consultation involves extensive questioning that may cover unfamiliar ground for those who are used to a few quick questions from a busy doctor. To better prepare you for the consultation, and the kinds of information the homeopathic physician requires are described below.

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First, you will be asked to briefly list the conditions that have caused you to seek treatment and for how long you have had these problems. It is a good idea to mention these main problems in order of importance.

Next, you will be asked to describe each of these conditions in your own words, as fully as possible. Include everything that is characteristic of your problems. *Precise details are best*, but only if you can be definite about them. If applicable, your account should include, but not be limited to:

**CHARACTER OF SENSATION or PAIN.** Does it feel tingling, burning, numb, crawling, pressure, or itching, etc.? Is the pain cutting, dull, aching, or cramping? These are suggestions only.

**LOCATION** of the complaint as precisely as possible. For example, "pain in the left temple" is more helpful than simply "headache".

**DISCHARGES** or bleeding from any part of the body. Give color, consistency, quantity, and odor of the discharge.

**AGGRAVATING OR AMELIORATING FACTORS.** What makes your complaint better or worse? Does your condition vary with time of day or night or season of the year? Is it affected by your position (sitting, standing, lying, etc.) or by activity (motion of any body part, walking, vigorous exercise, rest, etc.)? How does temperature, weather, eating, and sleeping affect your condition? **ANYTHING** that clearly influences the intensity or pattern of your symptoms should be reported.

**CONCOMITANTS.** Does anything regularly occur in association with your symptoms? Are you always nauseated when you have a headache? Does your skin clear up during your premenstrual symptoms?

**ONSET OF SYMPTOMS.** Do you associate the onset of your condition with any emotional upset, prolonged or pronounced stress, lack of sleep, exposure to weather, an injury, drug use, or surgery, or any other factors? Does anything cause a recurrence of your symptoms?

**GENERAL INFORMATION.** In addition to information about your primary problems, the homeopathic doctor needs to know a lot about you in general. This is important, and may be decisive when choosing the remedy.

How vital and energetic do you feel? How does your sense of well-being (not any particular symptom), change as a result of environmental or emotional factors? How are you affected, in general, by temperature, weather, time of day, activity level, eating and sleeping? What makes you feel better, what worse? This may be different from what makes a particular symptom better or worse. Please complete the questionnaire carefully.

The doctor will also want to briefly know your LIFE HISTORY, including any traumatic emotional events or significant patterns.

Finally, the homeopathic doctor will want you to discuss your MENTAL/EMOTIONAL NATURE. During what activities or in which situations do you feel most emotional? What are your most characteristic emotional patterns? What limits your ability to express yourself fully? What about your memory, clarity of thought, ability to create, and so on?

Feel free to think about these questions before hand and jot down some notes for yourself to use during the interview. How you say things is also important, so please don't be offended if the doctor asks you to put those notes aside for a while during the interview. There will be time later to get back to them.

PREVIOUS MEDICAL RECORDS are always helpful. Please bring copies along with you if possible.

#### PHYSICAL EXAMINATION AND LABORATORY

The first determination that the homeopathic doctor must make is an accurate diagnosis of your condition. For this reason a physical examination is done and laboratory tests and x-rays are ordered when they are deemed necessary.

#### HOMEOPATHIC CONSULTATION FOR ACUTE DISEASES

Acute diseases require a shorter visit, usually 20-30 minutes. During this type of visit chronic symptoms will be ignored and only those symptoms that have arisen at the time of the acute disease will be considered. You will still need to relate your symptoms with as precisely and with as much detail as possible. Physical exam is usually limited to those procedures necessary for that particular acute condition. Again, lab tests or x-rays will be ordered as required.

#### TREATMENT

Based upon the information you provide, as well as the results of physical examination and appropriate laboratory tests, you will be given a remedy to begin stimulating the healing process.

If you are being treated for a chronic condition you will usually be instructed to take a single dose of your remedy in the office. If you have used or taken something like coffee or camphor that day you may be given the remedy to take home and take later. This single dose will be all that you require for a month or more. Acute cases and certain chronic cases often require more frequent doses. A dose usually consists of three or four of the round white pellets in the vial you will receive.

Please follow the instructions you will be given about how to take and store your homeopathic medicine as well as what to avoid during treatment. If you have any questions about this please ask anyone on the staff.

#### WHAT TO EXPECT

During an acute illness you should notice improvement within the first 24 hours, though you will still require a normal, gradual convalescence.

While undergoing chronic treatment, each individual reacts to the remedy in a different way. Usually the effects are gentle and gradual, though at times more rapid or dramatic changes occur. Since the remedies work to improve your general health, you should not be concerned if local symptoms do not change immediately. Patience is a necessary ingredient you must add to the treatment.

Temporary minor aggravations of symptoms or recurrences of previously experienced symptoms sometimes occur. These are not side effects of the remedy, but an indication that the body is responding to the medicinal stimulus. If any reaction occurs that concerns you, do not hesitate to call the doctor.

People with chronic problems improve over widely varying periods of time, usually 3-24 months. This is the time necessary to complete the cure. You will, however, experience definite improvement in your symptoms within a few weeks of starting the correct remedy. During the whole of this time, regular follow-up visits are essential to nurture the healing process through the inevitable remedy changes and occasional setbacks that occur.

These follow-up visits are scheduled at varying intervals anywhere from three weeks to six months depending upon the individual characteristics of each person's progress.

**FOLLOW-UP APPOINTMENTS** Follow-up appointments are very important. Often they will be scheduled even when you are doing well or continuing to make progress. This sometimes seems unusual or unnecessary to patients unfamiliar with homeopathy. We're all used to the conventional idea of going to the doctor only when we are sick. However, our observation has been that those patients who return for their regularly scheduled follow-up appointments complete their homeopathic treatment in shorter time and with better results.

Although you may be taking homeopathic medicine and be under active care for as long as two or sometimes three years it is important to keep in mind that the ultimate goal of homeopathic treatment is to reach a high level of health without being dependent upon any medication.

#### COMPREHENSIVE CARE

Homeopathy can be used as a comprehensive medical system as well as for the treatment of specific complaints. Once the treatment of a specific disease is complete, the homeopathic remedies can be used to strengthen the person's emotional life. This will help to prevent disease in the future by increasing the person's resistance to emotional stress. After this, yearly or biyearly doses of their "constitutional remedy" will also act to prevent disease in the future by maintaining the body in its best possible condition. Of course, lifestyle and diet are also important in preventing disease.

REFERENCES: Readily available in Eugene

EVERYBODY'S GUIDE TO HOMEOPATHIC MEDICINE by Cummings and Ullman.

DISCOVERING HOMEOPATHY by Dana Ullman.

HOMEOPATHY: MEDICINE OF THE NEW MAN by George Vithoulkas.

THE PATIENT NOT THE CURE by Marjorie Blackie.

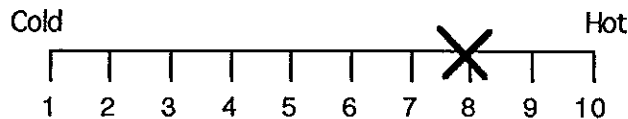
Please answer the following questions as carefully and thoughtfully as possible. Homeopathy individualizes each prescription to the person as well as to the disease symptoms. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking homeopathic care. The answers to these questions, as well as the information that you provide in the office, will determine which homeopathic remedy we begin your treatment with. Please take enough time and answer carefully and accurately. ALL THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL BY LAW.

This questionnaire has been designed to make this process easy. You can answer many of the questions by placing an X in the appropriate place on the line given. Some questions will ask you to decide between two opposite symptoms.

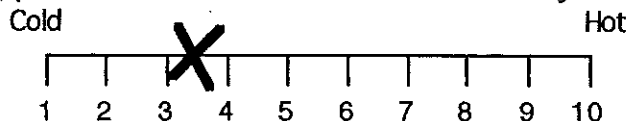
For example: If you are asked whether you are generally hot or cold. Place your mark along the line to indicate how hot or cold you are.

Placing an X closer to the hot end of the line means that you are more hot. Placing your X closer to the cold end means you are more cold.

For example: If you are hot, put an X in the appropriate place on the line to indicate how hot you are.

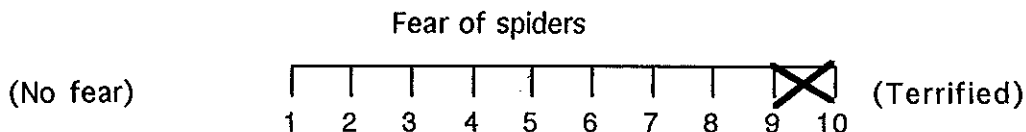


If you are cold, place an X on the line to indicate how cold you are.



Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. The number one means that you are troubled very little, or not much characterized in general, by that symptom. The number ten means you are troubled very much or characterized a lot in general by that symptom.

For example: You are asked whether you have a fear of spiders. Make an X on the line to indicate the degree to which you are troubled by that symptom.



Some questions ask you to circle the answer you think best fits you. For example:

Feeling toward disease/condition

Optimistic

Doubtful of recovery

Discouraged

Fearful

Despair of Recovery

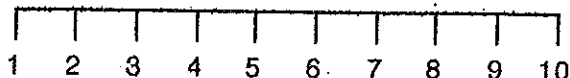
NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

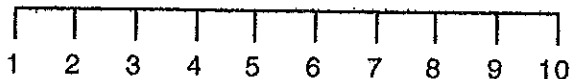
The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

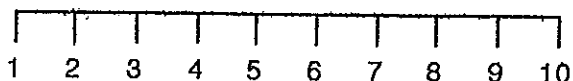
Cloudy Clear



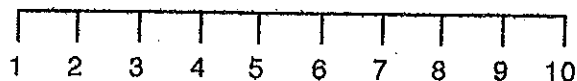
Wet Dry



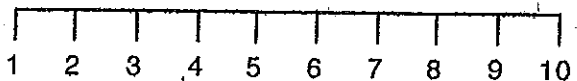
Damp cold Snow (Dry Cold)



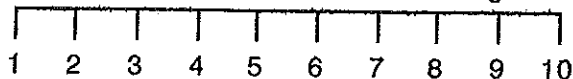
Storms



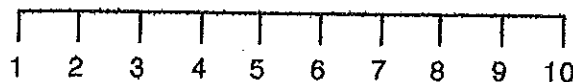
Wind



Fog



Hot Sun



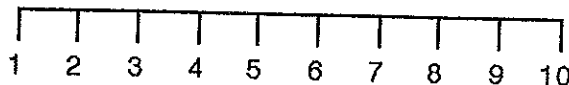
Circle which seasons cause you the most trouble ?

Winter  
Spring  
Summer  
Autumn

Are you more sensitive (worse) to being in the?

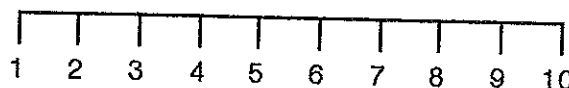
Mountains

At the seashore

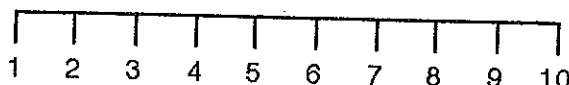


Are you generally sensitive to and/ or troubled by:

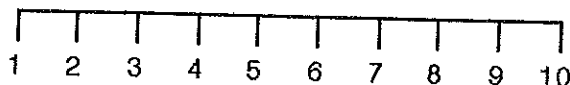
Bright light



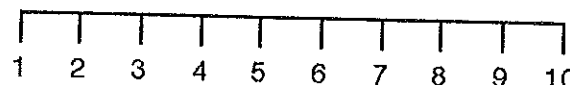
Darkness



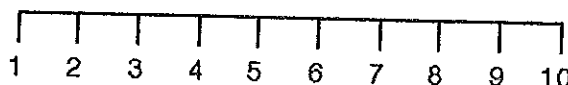
Open air



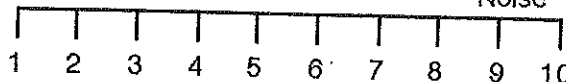
Stuffy rooms



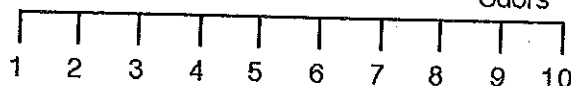
Tight clothing



Noise



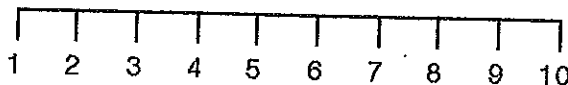
Odors



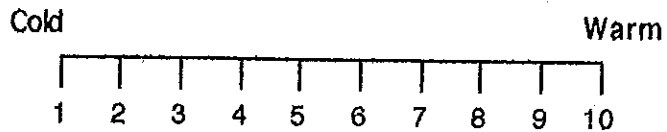
Are you generally chilly or warm ?

Chilly

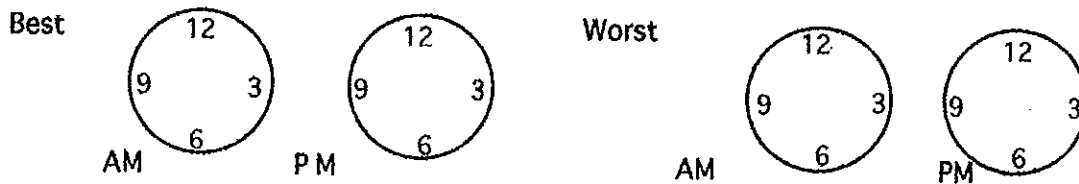
Warm



Which are you generally most sensitive to:  
warm or cold?



What times of day are you generally worst  
(mood, energy, symptoms, etc.) What  
times are you best?



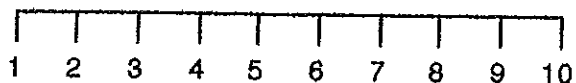
Symptoms during sleep. Circle which you  
have?

tooth grinding  
restlessness  
talking  
perspiration  
frequent urination  
excess heat or cold  
laughing  
snoring  
nightmares

What position do you sleep in most often?

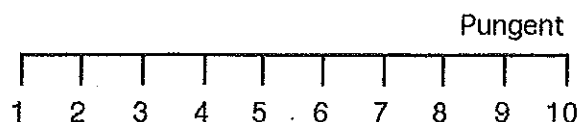
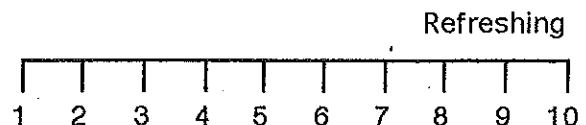
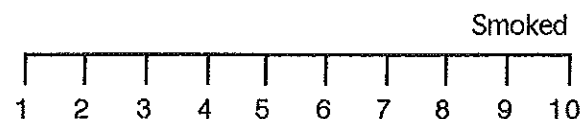
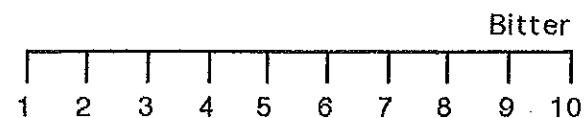
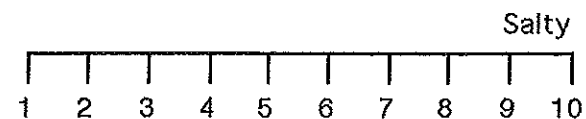
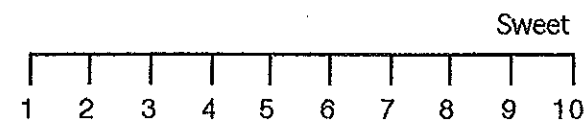
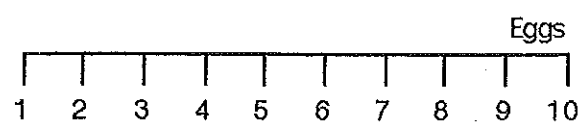
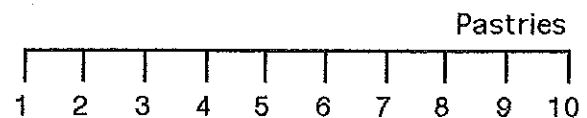
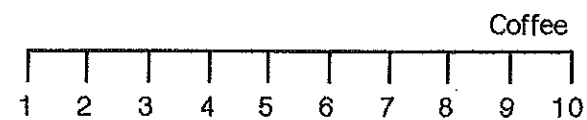
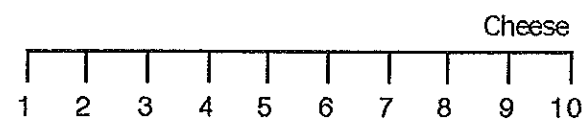
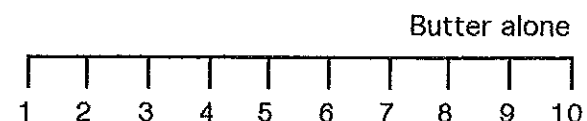
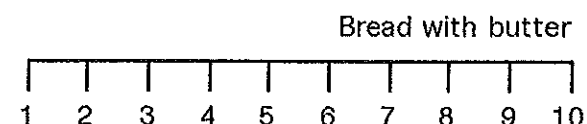
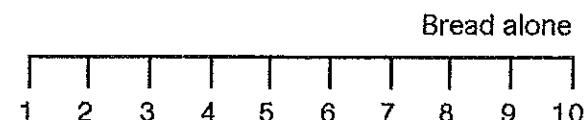
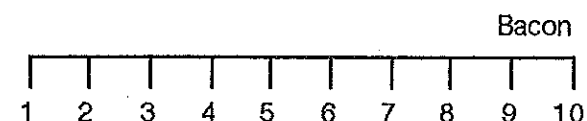
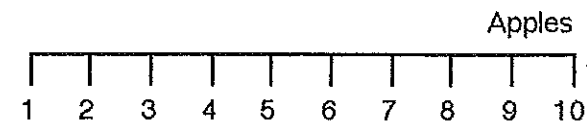
Right side  
Left side  
On back  
On abdomen

How much do you perspire?

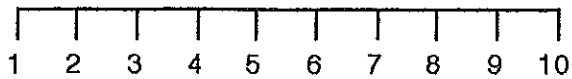


**Food Desires and Aversions:**

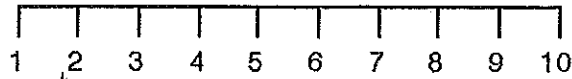
In the following questions you are asked to rate how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

**Tastes:****Foods:**

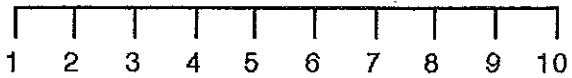
Fat (meat, chicken, pork, etc.)



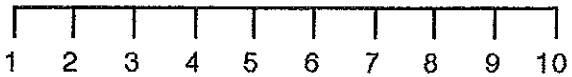
Fish



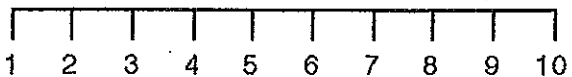
Fruit



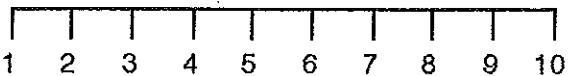
Fruit (sour)



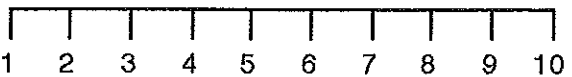
Grain products (pasta, bread, cereal, etc)



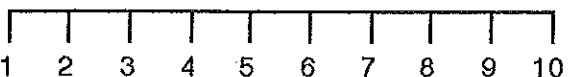
Ham



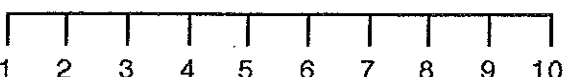
Ice



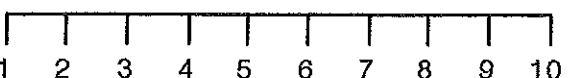
Ice cream



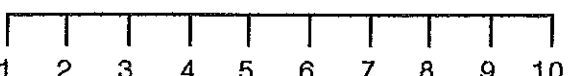
Indigestible things (chalk, clay, paper, etc)



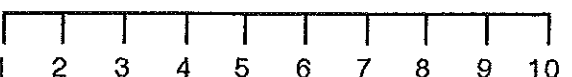
Lemonade



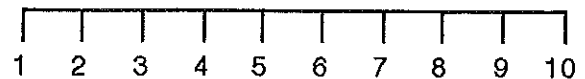
Meat



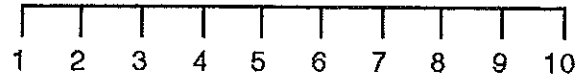
Milk



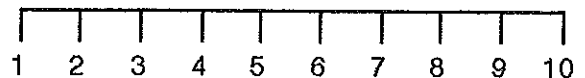
Nut butters



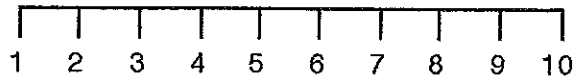
Oysters



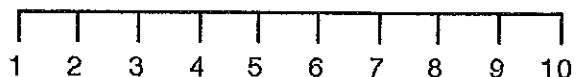
Pickles



Vegetables

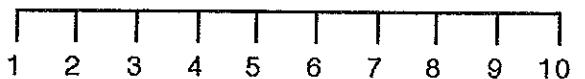


Vinegar

Temperature of food? (which do you prefer?)

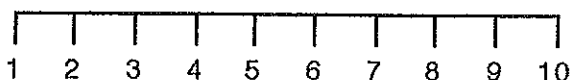
Warm food

Cold food



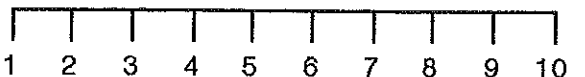
Warm drinks

Cold drinks

How thirsty are you generally?

Not at all

Very

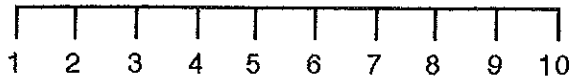




How often are you troubled by any of the following emotional or mental symptoms? The most mark 10. The least mark 1.

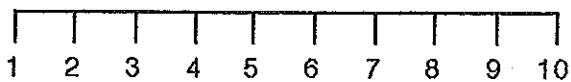
How strong in general are the following emotional symptoms?

Anxiety (worry and fear)

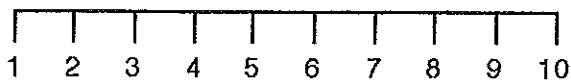


Do you worry about any of the following? 10 means the most 1 the least.

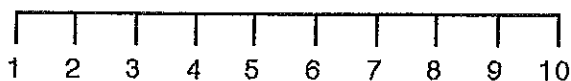
Creative activities



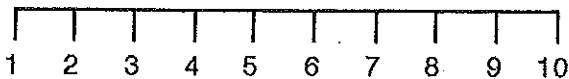
Emotions



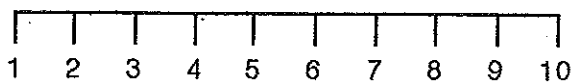
Financial security



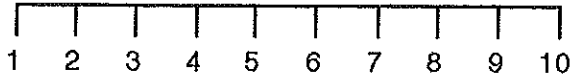
Health



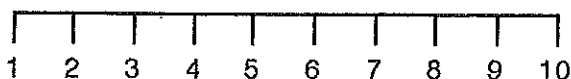
Mental functioning



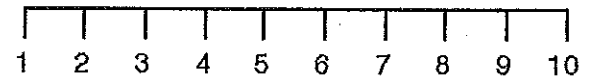
Morals/ past indiscretions



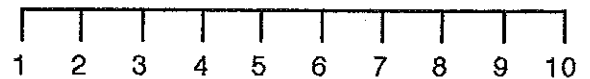
Others (family and close friends) well being



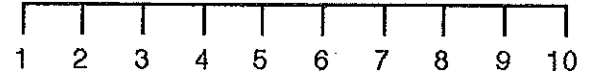
Religion



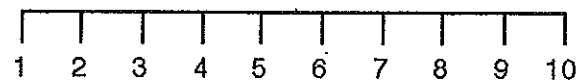
Social life



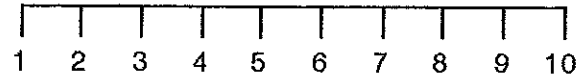
Social position



the Future

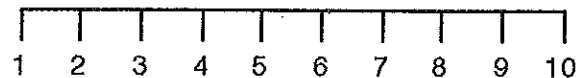


Work

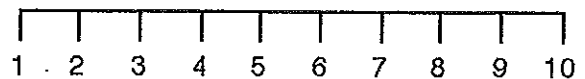


Again how often are you troubled by any of the following emotional or mental symptoms: The most mark 10. The least mark 1.

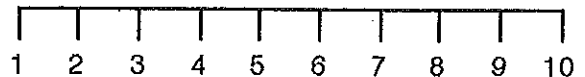
Irresolution (Not being able to decide or stick to a decision)



Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

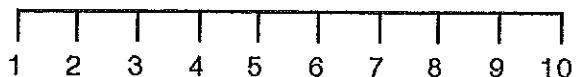


Selfishness



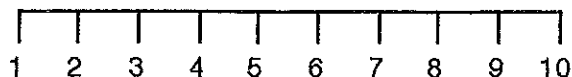
Frightened easily

Never Afraid

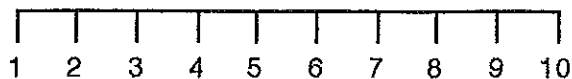


Answer as honestly as you can about your personality traits.

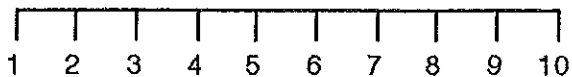
Stingy Overly generous



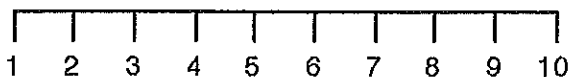
Thrifty Extravagant



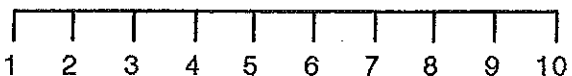
Hurried, impatient Slow



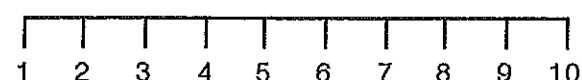
Messy Fastidious



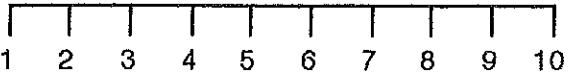
Restlessness



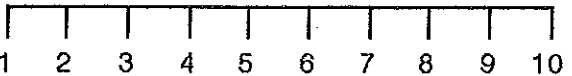
Indolence (Lazy) Always busy



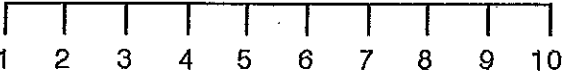
Shyness, Timid/ Bashful



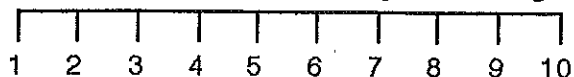
Anger Mildness



Lack of moral sense Guilty

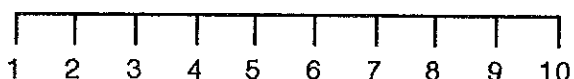


Religious feeling



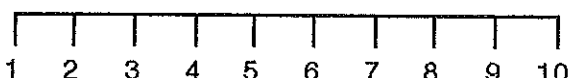
Obstinate (stubborn)

Yielding

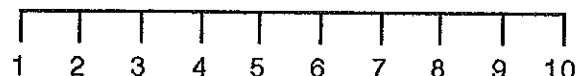


Heedless/Reckless

Cowardice



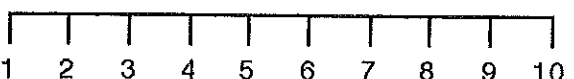
Envy



Social/Antisocial. In regard to being with other people or in company? —

Aversion

Desire for



Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events.

Resolved Grief  
Dwells on past  
Inconsolable  
Remorse  
Guilt

Feeling toward close others

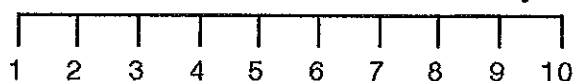
Loving  
Affectionate  
Indifferent  
Resentment  
Hatred

Feeling toward spouse/lover

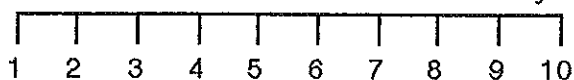
Loving  
Affectionate  
Dissatisfaction  
Disappointed  
Indifferent  
Resentment  
Hatred

How much do you have the following symptoms. 10 a lot, 1 hardly ever.

Irritability



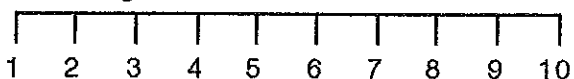
Jealousy



Mood

Alternating moods

Even Moods



Circle which expression best expresses your general mood.

Feeling toward disease/condition

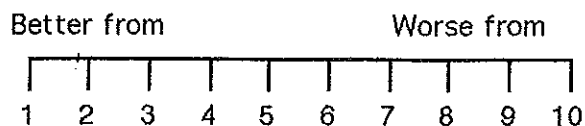
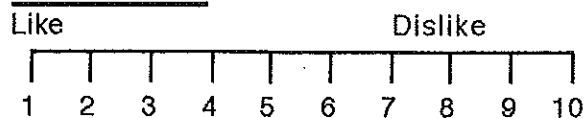
Optimistic  
Doubtful of recovery  
Discouraged  
Fearful  
Despair of Recovery

Feeling toward Life

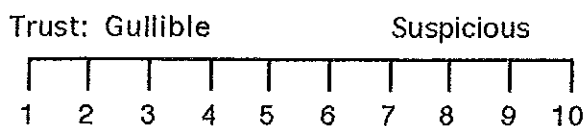
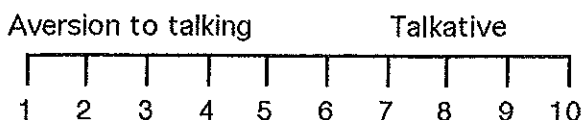
Love Life  
Indifferent  
Bored  
Weary of Life  
Loathing of Life  
Desires death  
Suicidal thoughts  
Suicidal disposition

Morose  
Sad  
Apathy/Indifferent  
Excitement  
Exhilaration

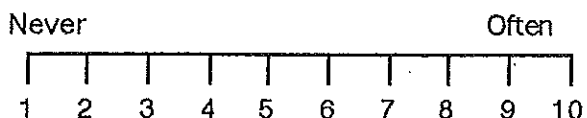
How do you experience sympathy or consolation?



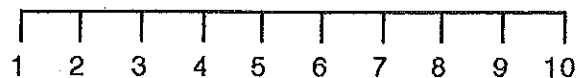
How talkative are you in general?



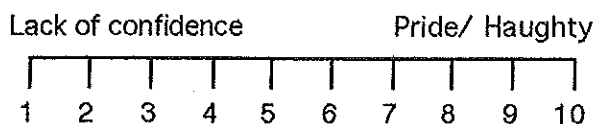
How often and easily do you weep?



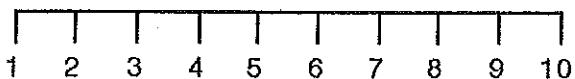
How often do you experience clairvoyance ?



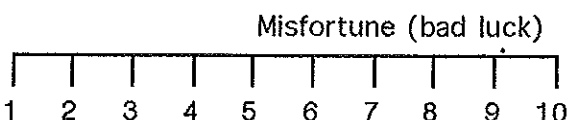
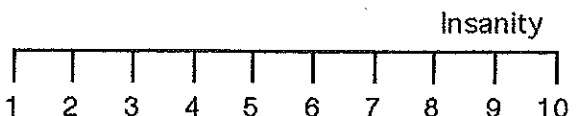
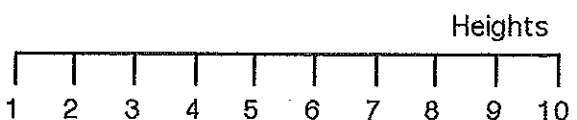
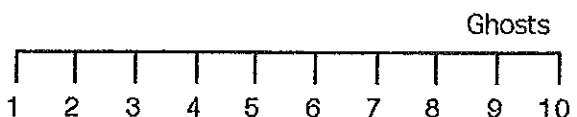
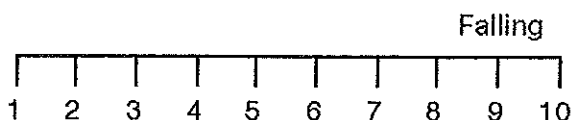
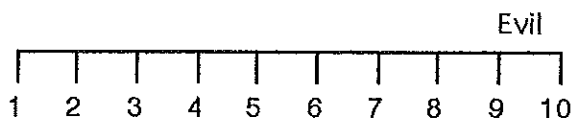
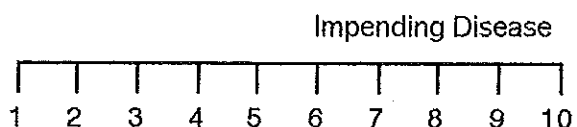
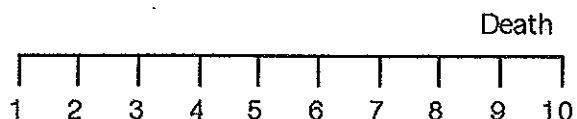
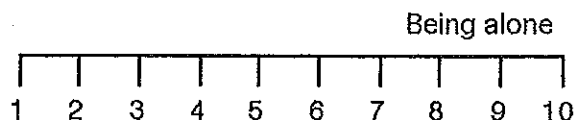
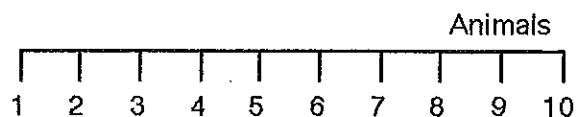
How is your level of self confidence?



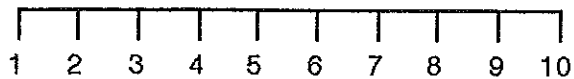
How impulsive are you?



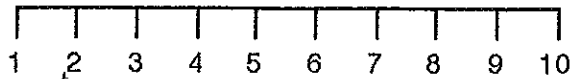
How afraid are you of the following?  
Again, 1 means not at all and 10 means the most.



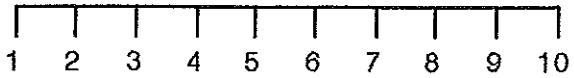
People



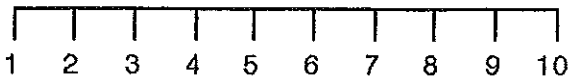
Robbers/ intruders



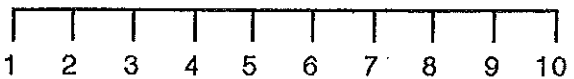
Snakes



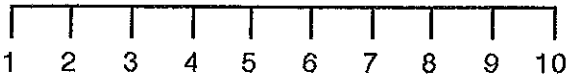
Spiders



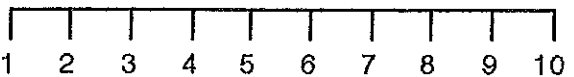
Strangers



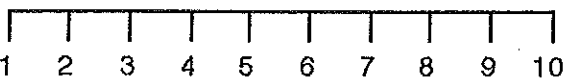
Having a stroke



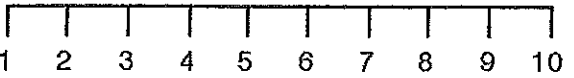
That something will happen



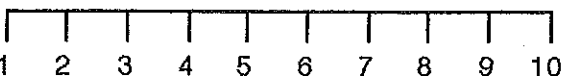
Darkness



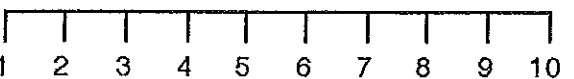
Thunderstorms



Water

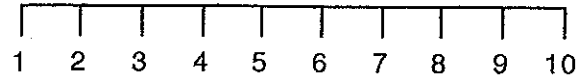


Wind

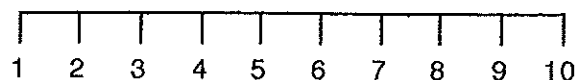


Are you forgetful for any of the following?  
(1 not at all, 10 a lot)

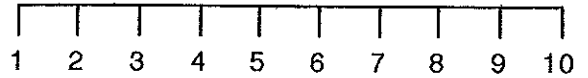
Dates



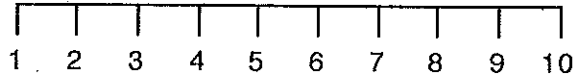
Names



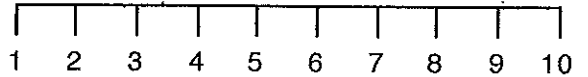
Numbers



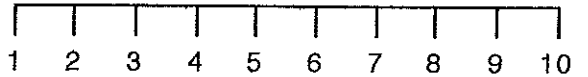
Of what someone else just said to you



Of what you just said

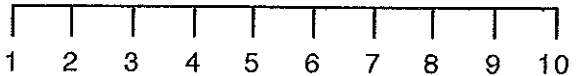


Of words

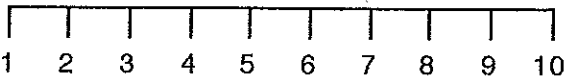


How often do you make mistakes with the  
 following?

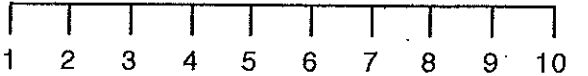
Numbers



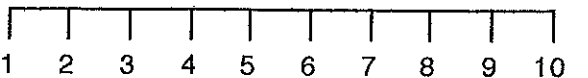
Words (reading)



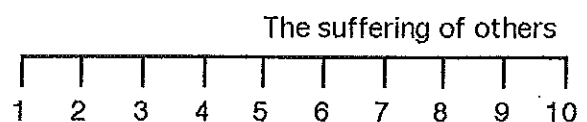
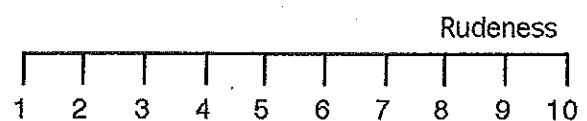
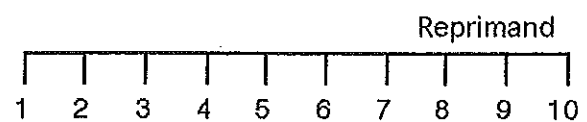
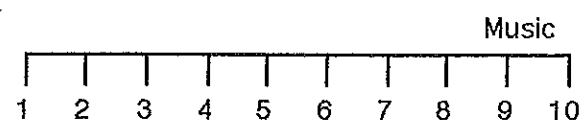
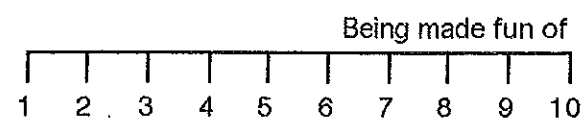
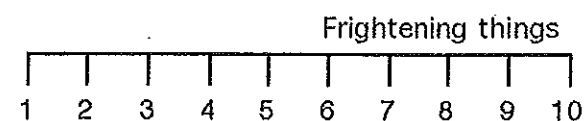
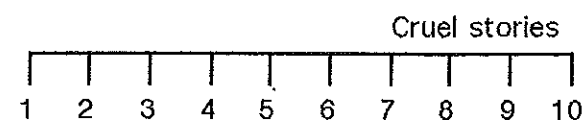
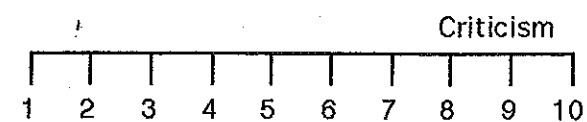
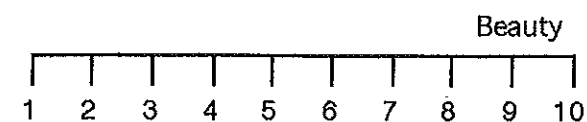
Words (speaking)



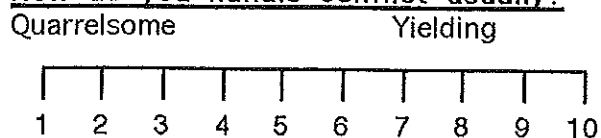
Words (writing)



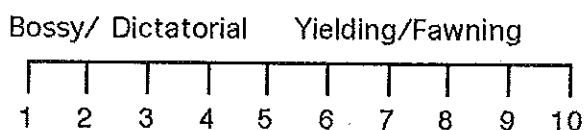
How sensitive are you to any of the following:



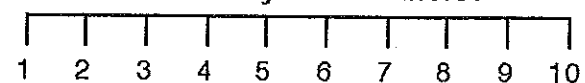
How do you handle conflict usually?



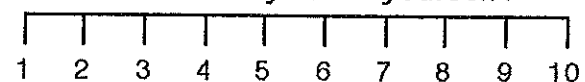
How are in regard to authority?



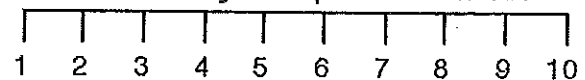
How critical are you of others?



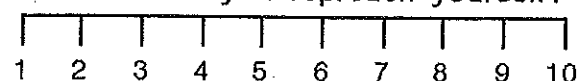
How critical are you of yourself?



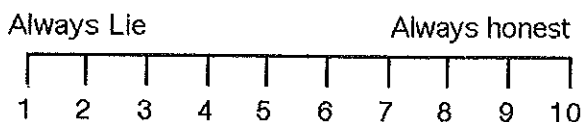
How often do you reproach others?



How often do you reproach yourself?

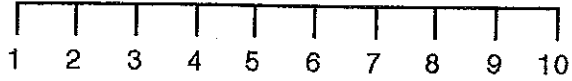


How honest are you?

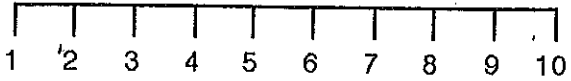


How often do you have the following behaviors?

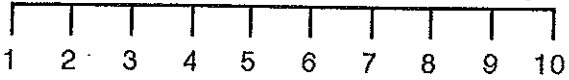
Abusive



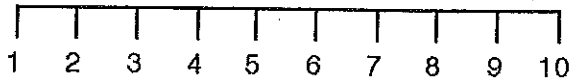
Biting



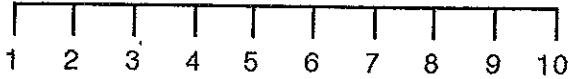
Breaks Things



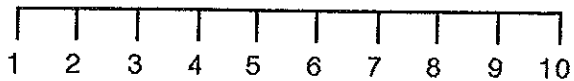
Contrary



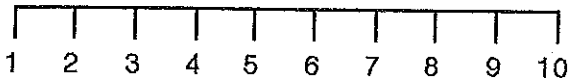
Cursing



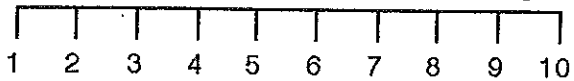
Disobedience



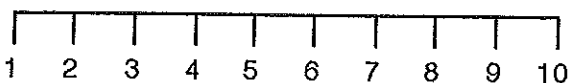
Insolent



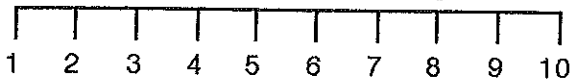
Rage



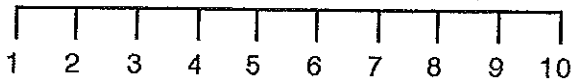
Rudeness



Striking others



Striking self



Violence

