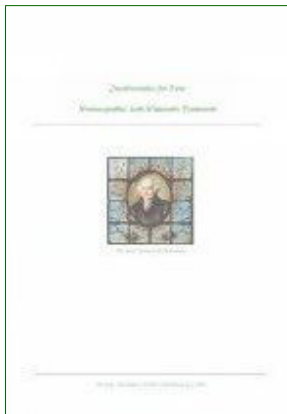


Questionnaire for Your Homoeopathic Anti-Miasmatic Treatment (EFB_e)



This questionnaire as well as the initial consultation will form the basis for your treatment according to the rules of Classical Homoeopathy.

The questionnaire alone is not enough to choose your homoeopathic remedy successfully. The personal interview is always the most important part. The questionnaire only serves as additional information and offers essentially three advantages:

- Your preparation for your initial interview including your chance to talk to your blood relatives about your family history of illnesses.
- Preparation for the therapist to think outside the box or to analyse any important coherences. He furthermore will probably be able to recognize any features which may seem unimportant to you or you have gotten used to for a long time.
- As an impulse for your subconscious mind to remember forgotten conditions.

Excerpt from the Homoeopathic Questionnaire

...

3. General Information

- 3.1 Please clap your hands once spontaneously (like applauding in the theatre). – Which hand is lying on top?
- 3.2 Are you right- / left-handed (perhaps retrained) / equally skillfull with both hands (ambidextrous)? / Does neither the left hand nor the right hand feel dominant (pseudo ambidextrous)?
- 3.3 Do you think you are too slim? – Despite having a good appetite? – What parts of your body do you feel are too slim (e. g. neck, legs, etc.)?
- 3.4 Do you feel too stout or too heavy? What parts of your body do you feel are too heavy or too stout?
- 3.5 Do you feel the cold easily or are you an extremely warm type?
- 3.6 How well do you tolerate hot / cold weather?
- 3.7 Do you suffer from hot flushes (perhaps caused by menopause)?
- 3.8 How well do you relate to fresh air? / Longing for fresh air? / Even known as fresh air fanatic? / Dislike fresh air?

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- 3.9 Have you ever fainted or suffered anything similar? / At what occasions?
- 3.10 How well do you stand sea voyages, traveling by car, traveling by plane or train?
- 3.11 Are you sensitive to noises? – At which occasions?
- 3.12 Are you sensitive to odours? – Which ones?
- 3.13 Have you ever noticed a particular smell on your own body (e. g. musty, sour, fishy, putrid, like stool)? – When? / Even after washing or taking a bath? / Where on the body? / Accompanied by secretions?
- 3.14 Can you stand a tight fitting collar, necklace or belt? – Do you like / dislike being touched at your neck?
- 3.15 Can you stand wool on your skin?
- 3.16 Do you experience symptoms or ailments repeatedly (by the hour, by the day, every few months, seasonally)?
- 3.17 Are there any symptoms, which have developed after you have been treated for another ailment?
- 3.18 When did your symptoms arise? – After a certain illness / after immunization / after a particular treatment / after an extreme fear or a mental shock? / Other causes?
- 3.19 Do your symptoms occur on a particular side of the body? – Predominantly left- / right-hand sided symptoms / moving from the left- to the right-hand side / moving from the right- to the left-hand side / moving from one side to the other (alternating)? / What else?
- 3.20 Are you very sensitive to touch? – Extremely ticklish? / Where in particular (e. g. on your spine, on your soles)?
- 3.21 Do you strongly dislike being touched or being looked at?
- 3.22 Do you have an increased sensitivity to pain? – Or are you extremely insensitive to pain?
- 3.23 Have you experienced peculiar or strange sensations in a specific part of your body? – Please describe in detail.
- 3.24 How does physical or mental strain influence your health?
- 3.25 Any accidents / bone fractures / brain concussions / surgery? / Any other reasons for having been in hospital?
- 3.26 Please list all of your current and past medication (continue on page 31, if necessary).
- 3.27 How was your health? / How did you feel before taking that medication?
- 3.28 Have you ever received chemotherapy? – Radiation-therapy? – When? / Why?
- 3.29 Have you ever taken any recreational drugs?
- 3.30 Do you have any foreign objects / implants in your body (e. g. nails / screws / pace maker / artificial hip joint / contraceptive coil / grommets / orthodontic braces or dentures)? – What else?
- 3.31 Are there any organs in your body, which are defective since birth? / Are you missing any organs?

4. *Weather Conditions and Influences by the Moon*

- 4.1 What kind of weather conditions do you prefer / do you not like at all? – Does sunshine, rain, humid weather has any influence on your wellbeing?

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- 4.2 How are you affected by draught / snow-air / strong wind / fog / before or during a thunderstorm / before or during a storm / changing weather conditions / cold / wet & cold weather / heat / föhn / full moon / new moon / waxing or waning moon?
- 4.3 How does your body react to extreme temperatures (hot/cold) or temperature changes?
- 4.4 How do you feel at the seaside / in the mountains?
- 4.5 How well do you cope with staying in humid places?
- 4.6 What other weather influences can you think of?
- ...

Excerpt from the Homoeopathic Questionnaire concerning the Blood Relatives

III. Blood Relatives:

*Please give a short account on all diseases and operations of your relatives (especially about striking, difficult, continuously returning and chronic disease, as well as tuberculosis, STDs, addictive and mental illness). Furthermore purulent and/or overgrown ear piercings, ingrown toe nails, increased nocturnal salivary flow, side effects from immunisations, a non-responding to immunisations (including tuberculin tests and immunisations against tuberculosis [BCG]) and similarly interesting things are of vital importance. – **Please research as thoroughly as possible.***

Please bear in mind, that two miasms are of venereal origin, that means they originated from sexually transmitted diseases, no matter how long they date back in time or inheritarily. For your own interest none of the topics should be a taboo for you.

Please state anything even from the past. Of specific interest are:

- Inherited diseases
- Chronically, continuously returning, extremely obstinate and/or difficult illnesses
- Side effects of immunisations / a non-responding to immunisations / tuberculin tests and immunisations against tuberculosis (BCG)
- Defects by birth / malformations / anomalies
- Neurological illnesses
- Epilepsy / tendency to cramps / Parkinson's disease / multiple sclerosis / paralysis
- Alcoholism / addictions
- Mental and affective disorders / M. Alzheimer
- Cause of death / suicide
- Migraine / meningitis / encephalitis (inflammation of brain)
- Eye complaints / astigmatism (corneal curvature)
- Illness pertaining your ears / purulent ear lobes from wearing ear rings (e. g. cheap fashionable jewellery), overgrown ear piercings
- Goitre / complaints of the thyroid gland
- Heart complaints / vascular diseases / venereal diseases / high blood pressure / stroke / arterio sclerosis

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- Lung diseases / bronchitis / asthma / tuberculosis / diphtheria
- Liver diseases / bowel diseases / stomach diseases / bladder and kidney diseases / tendency to inflammatory bowel diseases (e. g. nausea and vomiting)
- Rheumatism / gout / stones (gall / kidney / bladder) / increased uric acid
- Arthrosis of hip joint / hip displasia
- Cancer, what kind?
- Tendency to allergies
- Skin diseases
- Diabetes mellitus
- Overweight
- STDs / urological treatments (perhaps also treatments of your sexual partners) / genital fungal infections (with/without discharge)
- Increased nocturnal salivary flow
- Grinding of teeth during sleep
- Ingrown toenails / hang nails (curved upwards)
- Surgeries / hospital stays
- Malaria / typhus / travelling to tropical regions / travelling to Far East

Anything else?

36. Your Close Relatives

36.1 Mother – Year of birth..... :

36.2 Father – Year of birth..... :

36.3 Siblings:

36.4 Maternal grandparents:

36.5 Paternal grandparents:

36.6 Maternal uncles, aunts:

36.7 Paternal uncles, aunts:

36.8 Children:

36.9 Do you know any additional illness of your blood relatives (great-grandparents etc.)? – Please state the relationship to each list of symptoms.

36.10 Please give information about any gynecological or obstetrical problems amongst your female blood relatives (mother, grandmother, sisters, aunts, cousins, etc.). – *e. g. menstrual cramps, childlessness, artificial inseminations, miscarriages, premature births,*

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stillbirths, abortions, tubal pregnancies, placenta praevia, anomalies of presentation (e. g. breech presentation), placenta ectomy (afterbirth), caesarian section, retention of the lochia, mastitis, post-natal depressions, vaginal discharge, genital mycosis, genital herpes, condylomas, genital warts, any other warts, oophoritis, cysts, tubal blocks, metritis, endometriosis, myomas, cancer, surgeries, any discomforts due to menopause, etc.

Bücher für Ihre Gesundheit
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