

**Natalya Golovanov, N.D., CHom.
43 Quail Court Office Park, Ste.102
Walnut Creek, CA 94596**

NAME:	AGE:	DOB:
If Child, Parents Name:		
Address:		
Home Phone: ()		Work Phone: ()
Marital Status:	Number of Children:	Referred By:
Occupation:		

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

COMPLAINT	SINCE	CAUSES

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? PLEASE LIST. WERE THERE ANY MEDICATIONS THAT YOU TOOK REPEATEDLY FOR VARIOUS CONDITIONS?

MEDICATION	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT OR REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

<input type="checkbox"/>	Abscesses	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Tonsillitis

	Allergies		Emphysema		Herpes Genitalia		Parasites		Scarlet Fever		Tuberculosis
	Amnesia		Epilepsy		Influenza		Pelvic Inflammatory Disease		Sexual Abuse		Typhoid Fever
	Arthritis		Gall Stones		Kidney Disease				Skin disease		Venereal Warts
	Asthma		Goiter		Leukemia		Peritonitis		Strep Throat		Warts
	Cancer		Gonorrhea		Malaria		Pleurisy		Sinusitis		Whooping Cough
	Chicken Pox		Gout		Measles		Pneumonia		Sunstroke		Worms
	Cold Sores		Hay Fever		Miscarriage		Prostatitis		Stroke		Yellow Fever

Have you had any repeated infections of any kind in your life?

Any Other Major Conditions?

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Are there any events in your life which have changed you, or have not been completely resolved?

What operations have you had and when? Any complications?

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECT

Age of first menses: _____

Number of Pregnancies: _____

What vaccinations have you had? _____

Any adverse effects from the vaccinations?

Have you lost any weight lately? How many pounds? _____

What exercise do you do and how much? _____

How much of the following substances are you using:

TOBACCO: _____ ALCOHOL: _____ COFFEE: _____ RECREATIONAL DRUGS: _____

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR AILMENTS HAVE AFFECTED YOUR RELATIVES:

Alcoholism Allergies Arthritis	Asthma Cancer Depression	Diabetes Epilepsy Gonorrhea	Gout Hay Fever Heart Disease	Insanity Paralysis Pneumonia	Skin Diseases Syphilis Tuberculosis
RELATIVES	Ailments	AGE IF ALIVE	AGE AT DEATH		
MOTHER					
FATHER					
BROTHERS					
SISTERS					
CHILDREN					
Maternal Grandmother					
Maternal Grandfather					
Maternal Aunts/Uncles					
Paternal Grandmother					
Paternal Grandfather					
Paternal Aunts/Uncles					
Other					

Are you currently under the care of a physician(s)? For what conditions? What has your treatment been?

Have you used homeopathy before? When and for what condition?

FOR THE FOLLOWING LIST OF FOODS, INDICATE WHICH YOU REALLY LIKE, DISLIKE STRONGLY OR WHICH YOU CANNOT EAT:

UNDERLINE 1-3 TIMES FOR FOODS YOU LIKE (3 BEING THE STRONGEST); CIRCLE 1-3 TIMES FOR FOODS YOU DISLIKE (3 BEING THE STRONGEST); X OUT FOODS YOU CANNOT EAT.						
SWEETS	CHOCOLATE	SALTY FOOD	SPICY FOOD	EGGS		
SOUR FOODS: VINEGAR DRESSINGS PICKLES						
DAIRY PRODUCTS: CREAM BUTTER CHEESE ICE CREAM MILK						
MEAT: PORK BEEF CHICKEN FAT ON MEAT						
RICH FOOD: CREAM SAUCES						
TEA	COFFEE	BEER	WINE	SPIRIT	COLD DRINKS	WARM DRINKS
FRUITS:						
VEGETABLES:						
ANY OTHER FOOD OR DRINK:						

What types of weather do you like and dislike? Why?

What things give you the most pleasure in life? Why?

What things give you the most displeasure? Why?

List any fears and phobias you may have:

Do you sleep well? If not, why?

List any characteristic dreams you have now or had in the past. Include dreams which are/were vivid, recurrent or seemed important to you.

Additional comments: