Dr Benjamin J. Herr

M. Tech. Hom.
Registered Homeopathic Practitioner: A10626-HM
Licensed Compounding & Dispensing Practice: WC02098D

(near Cavendish Square)
"PLUM TREE COTTAGE"
6 FREDERICK ROAD
CLAREMONT 7708
CAPE TOWN

Pr No. 008000 0305782

OFFICE: 021 674 4476
CELL: 083 258 3728
info@homeopathycapetown.co.za
www.homeopathycapetown.co.za

Homeopathic Patient Questionnaire

****PLEASE ANSWER THESE QUESTIONS IN A SEPARATE EMAIL OR WORD DOCUMENT and send to us, number each section with only your answer, giving as much detail as possible.*** *(These questions are a guide; please feel free to add where needed.)*

1. General Information

- Full Name: [***Please do not answer on this document. Use a new document for only the answers & number each section accordingly.***]
- Date of Birth:
- Gender:
- Occupation:

2. Main Complaints

- Describe your primary health concern(s) in detail: [***Please do not answer on this document. Use a new document for only the answers & number each section accordingly.***]
- When did the symptoms begin, and what do you think triggered them?
- Where exactly do you feel the symptoms (location in the body) do they move somewhere else, does it favour one side (or area) of the body?
- How would you describe the sensation (e.g., sharp, dull, burning, throbbing, etc.), can you compare it to something familiar? (Be as specific as you can.)
- Are there any accompanying symptoms or changes noticed with your main complaint, does it behave differently at any time of day?
- Have you had any past episodes of this or similar conditions? If yes, how often?

3. Factors affecting symptoms

- What makes your symptoms better (e.g., rest, warmth, cold, pressure, change of position, etc.)?
- What worsens your symptoms (e.g., movement, time of day, eating, weather, etc.)?
- Do your symptoms change or alternate with others (e.g., skin rash followed by stomach pain, etc.)?

4. Sleep

- How is your sleep? Do you have trouble falling or staying asleep?
- Do you wake up frequently? If yes, at what times and why?
- Any specific sleeping position you prefer or avoid?
- Do you wake up refreshed or tired?
- Do you experience any dreams, nightmares, or disturbances while sleeping?

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5. Appetite, Thirst, and Food Preferences

- How is your appetite? Do you have cravings or aversions to specific foods?
- How much do you drink in a day? Do you prefer hot or cold drinks? Small sips or large amount at a time?
- Are there any foods or drinks that affect your symptoms?
- Do you experience any digestive issues (e.g., bloating, gas, acidity, nausea, fullness quickly, etc.)?

6. Stool and Urine

- How often do you have bowel movements? Any changes in frequency, consistency, or color? Anything that might affect or change this?
- Do you experience any discomfort, pain, incomplete stool or other sensations with passing stool or urine?
- Any issues with urination (e.g., frequent urge, burning, dribbling, etc.)?

7. Menstrual / Sexual Health *(if applicable)*

- Are your menstrual cycles regular? Do you experience any discomfort, mood changes or other symptoms **before, during, or after** your period? What is the duration and interval of your cycle?
- Are there any changes in the flow – scanty, heavy, clotting or irregular?
- Any concerns or changes in sexual health?

8. Energy Levels

- How is your overall energy? Is there any time of day when you feel better or worse?
- Do you experience fatigue or bursts of energy? If yes, when and why?
- Do you feel more energized or sluggish with certain activities (e.g. mental activity) or environments?

9. Temperature Sensitivity

- Do you feel generally hot or cold? Do you prefer warmer or cooler environments?
- Are you sensitive to weather changes (e.g., rain, wind, sun, clouds, etc.)?
- Do your symptoms improve with fresh air, or worsen when in a draft?
- Do you sweat more than usual, or in specific areas of the body (e.g., head, palms, etc.)?
- Do some parts of your body feel hot and others cold, describe?

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10. Mental and Emotional State

- How would you describe your general mood (e.g., anxious, sad, irritable, content, etc.)?
- Does your mood change throughout the day and if so how, and what may cause the change?
- Are there any recent emotional events (e.g., grief, stress, excitement) that may have impacted your health?
- How do you feel in social situations?
- Do you feel better or worse after expressing emotions (e.g., crying, anger, etc.)?
- Are there any fears, anxieties, or recurring thoughts troubling you (e.g. fear of being alone, darkness, the future, etc.)?
- Which of the following *best* describes you (**choose only one**):
  A. **Sanguine**: Sociable, outgoing, optimistic, and thrives on fun and interaction.
  B. **Choleric**: Ambitious, driven, decisive, and naturally takes charge.
  C. **Melancholic**: Thoughtful, analytical, sensitive, and perfectionistic.
  D. **Phlegmatic**: Calm, laid-back, empathetic, and values peace and harmony.

11. Physical Activity

- How physically active are you on a daily basis? Any changes in your routine lately?
- Do you experience pain, discomfort, or other symptoms with movement or exercise?
- Do you feel better or worse with rest, or after being active?
- Do you experience cramps, stiffness or joint pain after exercising?

12. Environmental & Lifestyle Factors

- Do you have any known allergies (e.g., food, environmental, etc.)?
- Describe your living environment (e.g., city, rural, humid, dry, etc.).
- How do you feel in crowded or enclosed spaces?
- How is your stress level, and what causes it the most in your life?
- Any notable changes in your life recently or around onset of symptoms (e.g., job change, moving, relationship changes, etc.)?
- Do your symptoms change when you travel?
- What religious belief do you hold and what role does it play in your life?

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13. Past Medical History

- Have you had any major illnesses, surgeries, or accidents in the past?
- Any family history of similar or major health conditions (e.g., diabetes, asthma, cancer, etc.)?
- Have you observed any patterns of illness in your life?
- Please give a one paragraph biography of your life (not just medical history)?

14. Medications & Treatments

- Are you currently taking any medications or supplements? If yes, which ones?
- Have you undergone any other treatments, if so please describe?
- Have you taken homeopathic remedies before? If yes, which ones and what was the outcome?
- Have you had any reactions to medicines in the past?

15. Additional Information

- Is there anything else you think is relevant to your health or symptoms that hasn’t been covered?