

Special Homeopathic Questioner Form

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Name _____ Birth date _____ Date _____

The following are your personal and private medical records. These will not be shared with anyone unless you specifically request.

A lot of what Dr. Laursen can do for you is based on how much he knows about you. A lot of what you can change about yourself depends on how much you know about yourself.

Please answer the following about your inner and outer life:

Please tell me the details about ALL the issues or concerns you have regarding your **physical health, mental, spiritual and emotional life**. With EACH issue or awareness, let me know what makes it better, and what makes it worse. Let me know the **time of day** the situation is present, better or worse. For physical symptoms, describe exactly where you feel it and on what side of the body. For issues of pain or numbness, describe the pain in your own words and if the pain is constant or intermittent. **The more specific and unique your feelings or lifestyle, the more useful is the information you give.** Tell me about yourself...

These are my most hidden traits:

Name things rare, unusual or significant about yourself:

Do you wear your clothes loose or tight? _____

What are your major past disappointments or regrets? _____

Decision-making is easy or do you procrastinate? _____

Do you have nasal congestion? _____

Do you have a fear of public speaking? _____

What are your hobbies? _____

What gives you joy? _____

What would be your preferred occupation? _____

What is your current occupation? _____

Tell about your perspiration. _____

List all your pains with descriptions:

How many children do you have? _____

Menstrual history, problems? _____

How do you feel before, during, and after menses? _____

Describe any discharges you have. _____

Do you like cloudy weather, hot or cool? _____

What vaccines have you had and when? _____

Can you eat spicy food? _____

Do you have any mind racing? _____

Any problems with your senses: hearing, smell, sight, taste, feeling? Please list:

Do you have any dental problems? _____

What therapies have you tried in the past? _____

Married, divorced or single? _____

Childhood – What was it like for you? _____

Describe your typical eating habits:

Breakfast – What time? _____ What do you eat? _____

Lunch – What time? _____ What do you eat? _____

Dinner – What time? _____ What do you eat? _____

Snacks – What times? _____ What do you eat? _____

Bedtime – What times? _____ What do you eat? _____

Are your fingernails cracked, ridged or colored? _____

How many moons do you have on your 10 fingers? _____

How willing are you to be different? _____

List any peculiar and unusual symptoms:

Headaches, where, when, feel like? _____

Do you or have you done any sports? _____

How critical of others are you? _____

What are your top 5 complaints?

1. _____
2. _____
3. _____
4. _____
5. _____

Previous pregnancies? What were they like?

History of sexual abuse, age, situation?

Tell me of any prominent dreams?

Is your speech easy, fast, talkative, lisp, articulation, excessive, lifting, pessimistic? < (Circle)

Do you have any fears of survival? Why? _____

Are you self-destructive, self-defective? _____

Are you present or easily distracted? _____

Family Inherited Traits/Susceptibilities? _____

When was the last time you cried? _____

What foods do you crave? _____

What foods repulse you? _____

How is your appetite? _____

Any nausea or vomiting? _____

How are your bowel movements? _____

Any constipation or diarrhea? _____

What is your current menstrual history? _____

Any back problems? Where? _____

Any memory changes or problems? _____

Do you learn easily or with difficulty? _____

How many dental metal amalgams do you have? _____

How many hours of television do you watch per week? _____

Do you wear sunglasses all, most, some of the time? _____

Who is in charge of you? _____

What is your opinion of your self? _____

Please share past major experiences: _____

Is anything blocking you from healing or feeling better? _____

What symptoms would you have today if you were not using your current medications?

What symptoms would you have today if you had not had a surgical procedure?

What is your area of emotional discomfort? _____

What is your major conflict? _____

Any history of obsessiveness or compulsiveness? What? _____

Any history of hyperactivity or problem focusing? _____

List any cravings for any foods, or of sweet, salt, drugs, alcohol, nicotine. _____

Have you ever contemplated yourself? Or why you do what you do? _____

What angers you? _____

What frustrates you? _____

In what position do you sleep? _____

Do you follow a religious or spiritual belief system? Which?

If there is one thing you could do what would that be? (Circle)

- I enjoy being outside – mountains, rivers, lakes, oceans, meadows. (never) (a little) (some) (a lot)
- I enjoy green plants and trees. (never) (a little) (some) (a lot)
- I enjoy animals, big and small. (never) (a little) (some) (a lot)

- I enjoy groups of people. (never) (a little) (some) (a lot)
- I enjoy aloneness. (never) (a little) (some) (a lot)
- I enjoy a relationship with Spirit or God. (never) (a little) (some) (a lot)

Please state the major events in your life, in order starting from birth, and how these events affected you.

Please start with the emotional life of your parents during your gestation, if you know what that was.
