ANTICONVULSANTS

QUICK QUESTIONNAIRE FOR HOMEOPATHIC RECOMMENDATIONS

*Patient's Name:*_____ *Date:*_____

Yes	***No***	
☐	☐	Do you have seizures? What kind? _____
		How long have you had seizures? _____
		How often do you have seizures? _____
☐	☐	Before you had your first seizure, had anything changed in your environment?
		Where were you and what were you doing when you had your first seizure? _____
		Where were you and what were you doing when you had your last seizure? _____
		Describe your typical seizure. _____
☐	☐	Is there anything that triggers your seizure?
		What do you experience during the seizure? _____
		How long does it usually last? _____
☐	☐	Do you cry after a seizure?
☐	☐	Do you sleep after a seizure?
☐	☐	Do you get a headache after a seizure?
☐	☐	Do you get violent or combative after a seizure?
☐	☐	Do you know when you are going to have a seizure?
☐	☐	Do you see auras or smell anything before having a seizure? Describe. _____
		When was your last seizure? _____
☐	☐	Is there anything different at any time about any of the seizures you have had? Describe.
☐	☐	Do you have a history of allergies?
☐	☐	Have you been exposed to any toxins that you know of? If so, what? _____
☐	☐	Are you physically active or sedentary? Describe. _____
		How would you describe your diet? (What foods do you typically eat in a day?)
		Is your appetite good, fair, poor? _____
☐	☐	Do you crave any particular foods? If so, please list. _____
☐	☐	Do you have an aversion to any particular foods? If so, please list. _____
		What is your sleep pattern or quality like? (How many hours do you sleep, frequent awakenings, light sleeper, etc.) _____
☐	☐	Have you been diagnosed with diabetes?
☐	☐	Have you been diagnosed with hypoglycemia?

Yes	***No***	
		Do you feel:
☐	☐	Shaky or jittery?
☐	☐	Irritable if a meal is missed?
☐	☐	Tired or weak if a meal is missed?
☐	☐	Moody, nervous, impatient?
☐	☐	Tired 1-3 hours after eating?
☐	☐	Calmer after eating?
☐	☐	Awaken during the night craving food?
☐	☐	Do you crave sweets or carbohydrates?
☐	☐	Does eating sweets or carbohydrates relieve your symptoms?
☐	☐	Do you have increased or excessive thirst?
☐	☐	Do you have lowered resistance to infection?
☐	☐	Do you feel a pick-up after exercise?
☐	☐	Do you feel tired all the time?
☐	☐	Are you overweight?
		Describe your current bowel function. (How often do you have movements, is your stool hard, soft, etc., problems with constipation, diarrhea, color, odor, etc.) _____
☐	☐	Any changes in your bladder or kidney function? If so, please describe. _____
☐	☐	Do you experience any sadness or depression? If so, please describe.
☐	☐	Is it better or worse at any particular time of the day or month? What aggravates it or makes it better? _____
		How would you describe your personality? (Behavioral and emotional characteristics, i.e. impatient, easygoing, happy, sad, etc. _____
		How would others describe you? (Behavioral and emotional characteristics, i.e. impatient, easygoing, happy, sad, etc.) _____
☐	☐	Do you experience any restlessness? If so, please describe. _____
☐	☐	Do you have any fears? If so, please describe. _____
		What brings you pleasure? _____ What brings you joy? _____
☐	☐	Do you have nightmares or repeating dreams? If so, please describe. _____