The Homeopathic Consultation:

Preparing for your initial visit with Dr. DeLaney
Please read this introductory material -- then, complete the accompanying forms. This information can answer some questions you may already have about homeopathy, but more importantly, can help you get the greatest benefit from your initial visit with Dr. DeLaney. You can save this brochure for later reference as well.

What Is Homeopathy?
Homeopathy is a system of medicine based on the principle of "Like Cures Like." Homeopathy uses small doses of natural substances to stimulate the body's own healing mechanism.

"Like cures like" means that a substance that causes symptoms in a healthy person will cure them in an ill person. This was proven by Samuel Hahnemann, the founder of homeopathy who lived and practiced medicine in Germany in the 1700s. At that time, quinine was used to treat malaria. Hahnemann gave himself Cinchona Bark, the substance from which quinine was derived, and discovered he had symptoms identical to malaria. When he gave Cinchona Bark, in dilution, to someone with malaria, the patient became well. Through extensive research he found this principle applied to many, many other substances. In the last two centuries hundreds of substances have been tested in this way. These tests are called provings.

How Does Homeopathy Work?
When a substance has been proven, it is entered into a Materia Medica, a source-book for homeopathy physicians. These entries detail the physical, mental and emotional symptoms that correspond to each substance. A homeopathic physician meets with a patient for an extended consultation to develop a comprehensive symptom picture. The physician can then match the patient to the correct remedy. A homeopathic remedy is a non-toxic dilution of the original substance. Today they are prepared in federally regulated pharmacies.

Homeopathic treatment considers the whole person. Your symptoms -- whether mental, or emotional -- are considered expressions of your system's imbalance. Homeopathy treats not just you headache or your asthma but your total symptom picture with a remedy selected to correlate with your symptoms in order to assist your body in re-establishing its own natural balance. Supportive therapies such as nutritional supplements and herbs are also used to aid in this process.

During your initial consultation Dr. DeLaney will discuss with you in great detail your chief complaints, your likes and dislikes, your hopes and fears, and explore who you are as a person. Her choice of remedy is based on the information she gathers from you.

How Can You "Get the Most" From Your Visit?
An hour and a half for a physician visit may seem generous by today's standards but it is actually a short time to get to know someone "inside and out." It takes time to understand a person thoroughly enough to effect a lasting cure.

Any remedy prescribed for you is based on the totality of symptoms you describe, so it is vital that Dr. DeLaney have as much information about you and your symptoms as possible. Your willingness to prepare thoughtfully and thoroughly for your initial visit increases the likelihood that Dr. DeLaney will have the information she needs to choose the best course of therapy for you. More specifically,

Complete the enclosed forms
Some portions of the enclosed forms may be familiar, others not so. Each is designed, however, to help you explain your current condition and important related information in a way that gives Dr.DeLaney a complete picture of you as a person with likes, dislikes, a family, a history -- exactly what she requires to select an appropriate remedy. Please complete ALL parts of each form.

Think about your symptoms & how best to describe them
When you discuss with Dr. DeLaney the conditions or problems that bring you to her, try to be as specific as possible. You can use the questions below as a guide and even make notes if that will help you remember. For instance,...

Onset/recurrence of symptoms
Did the start of your problem/condition coincide with any occurrence, emotional upset, or stress? lack of sleep? exposure to weather? an injury or surgery? any kind of excess (alcohol, food, etc.)? anything else different?
Does anything seem to cause a recurrence of your symptoms? ... a disappearance of your symptoms?

Location of complaint
Be specific: “Pain in left temple” is more helpful than “headache”

Description of sensation or pain
Is the feeling burning? tingling? crawling? itching? pressured? numb?
Is the pain cutting? aching? cramping? pulsing or throbbing? other?

Worsens or improves complaint (applies to emotional, mental, & physical concerns)
Does it vary with the time of day or night? the season? the weather? Try to be precise, e.g., “walking at midnight” vs. “walking during the night”
Is it affected by your position -- sitting? standing? lying? lying on left? lying on right?
Is it affected by activity -- walking? running? resting? moving in a specific way?
Does temperature (cold or warmth) affect your condition?
Does eating or sleeping have an affect? Not eating? Not sleeping?

Associations with complaint
Does anything occur regularly in association with your symptoms - nausea with headaches? skin clearing during menstrual cycle?

What Happens Next?
Dr. DeLaney may send you home with a remedy and/or other recommendations after your visit, or she may want more time to consider the specifics of your condition. Directions will be provided for any remedy given to you and a follow-up appointment will be made for you before you leave the office.

RELEASE AND PERMISSION FORM

DATE_____

I understand that Dr. Susan DeLaney is not a licensed medical doctor in the state of North Carolina but has a license for Naturopathic and Homeopathic medicine from the state of Oregon.

I understand that Dr. Susan DeLaney can not file insurance nor prescribe prescription medications. I understand that Dr. Susan DeLaney will be treating me with homeopathic remedies and supplements that sometimes do not have an immediate effect.

I understand that I am responsible for all charges that I incur during my visits and payment is due at time of service.

_____ _____

Print first and last name Signature

Thank you,

Dr. Susan DeLaney

Name	
Address	
	Zip Code
Home Phone	Work Phone
Occupation	**Email**
Birthdate	Age

Relationship Status (check all that apply)			
Married____	Single____	Divorced____	Widowed____

What is your religious preference, if any?

Other people in household? First name	Relation	Age

Any pets in household?

Hobbies and/or special interests

Ht.	Wt.	B/P	Chol.

Name _____ Phone number _____

1 What is the main problem you want help with?

2 List any other problems you want help with

3 List all medications you are currently taking (incl. contraceptives)	How long have you been taking it?	Reason for taking it?

4 List all medications you have taken in the past	How long did you take it?	Reason for taking it?

5 List all vitamins/supplements you are currently taking	How long did you take it?	Reason for taking it?

6 List any allergies (food, drugs, pollens, etc.)

7 Date	List major illnesses, hospitalizations, surgery

8 List the name and type of other health care providers that are treating you (chiropractor, therapist, primary physician, etc.)

If you need additional space for any of the above items, please attach a sheet and the corresponding number.

Name _____ Phone number _____

If you have ever had any of these conditions, *please circle them.*

Allergies	Jaundice	FOR MEN
Anemia	Kidney disease	
Arthritis	Kidney stones	Prostate Problems
Asthma	Mental Disorder	
Bleeding Disorder	Migraine	FOR WOMEN
Colitis	"Nerves"	
Depression	Pneumonia	Breast problems
Diabetes	Seizures	Cystitis
Gallstones	Sinusitis	Endometriosis
Glaucoma	Skin disease	Fibroids
Heartburn	Sleep disorder	Hysterectomy
Heart disease	Stroke	Pelvic infection
Hemorrhoids	Thyroid problems	Vaginitis
Hepatitis	Tuberculosis	
Hernia	Ulcer	How many times have you been pregnant?
High blood pressure	Vomiting blood	
High cholesterol	Warts	

Indicate below which ailments have affected your relatives. Give ages even if they are/were healthy. Do/Did they have the same ailments as you? Possible ailments: AIDS, alcoholism, allergies, arthritis, asthma, cancer, diabetes, epilepsy, frequent colds, gonorrhea, gout, hay fever, heart problems, hysteria, mental illness, obesity, paralysis, pleurisy, pneumonia, skin affections, syphilis, thyroid problems, tuberculosis, ulcers, warts, and other problems in your family.

	Age if Alive	Age at Death	Ailments
Mother:			
Father:			
Sisters:			
Brothers:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

Name _____ Phone number _____

DIET DIARY

Please list everything that you eat or drink for three full consecutive days. If you are a nursing mother and this appointment is for your nursing child, please list *your* diet.

	DAY ONE	DAY TWO	DAY THREE
BREAKFAST			
LUNCH			
SUPPER			
SNACKS			
EXERCISE			
MISC.	SMOKING – If you smoke, how many packs a day? ALCOHOL –How many drinks per week? RECREATIONAL DRUGS – What and how much a week? COFFEE – How many cups a day? COLA/SODA – How many glasses a day?		

Name _____ Phone number _____

Please write a brief outline of your life history. Beginning with birth or early childhood, list major illnesses, injuries or hospitalizations, significant turning points or major events in your life. Please include periods of eating disorders, heavy alcohol, cigarettes, coffee, pharmaceutical or recreational drugs, and major deaths or illnesses in family. For women, also include events related to your reproductive system (first period, menopause, pregnancies, abortions, birth control, etc.). If you are filling this out for your child, please include any notable information about the pregnancy and nursing. Keep it brief and simple, we will go into detail as needed.