CASE – HISTORY FORM

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM.

Homeopathic remedy is mainly selected on the information you provide about your sickness as well as yourself.

For making a successful prescription, it is extremely important to understand the details of symptoms you experience. We must also know all the attributes that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

To gain this information, you will be asked many questions. Each one of these questions is significant for homeopathic treatment. Often, something that you may think has no connection with your disease symptoms, may be the most significant information for selecting the accurate homeopathic remedy for you. Please read each question carefully, think and if necessary, consult someone close to you and then answer completely. Describe everything freely and frankly without any hesitation. **REMEMBER, WHATEVER YOU TELL US WILL REMAIN ABSOLUTELY CONFIDENTIAL.** Your co-operation is extremely important for the process of choosing the appropriate homeopathic treatment and enhancing your health.

THIS QUESTIONNAIRE FORM HAS 2 SECTIONS:

Information about Illness

1. Describe your chief complaints in your own words with the history of the onset.
2. For any additional complaints, please read the instructions on how to report each of your complaints. Then make a list of your complaints and describe each of them according to the instructions.
3. Describe your past illnesses and family illnesses. Please take time to answer this part with the help of your family members before coming to us.

Information about you as an Individual

1. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Also, include your nature as a child.
2. About your sleep and dreams.
3. Provide information about all the parts of your body.
4. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.

CHIEF COMPLAINT:

Describe your chief complaint in as much detail as possible including the history of the onset and course of these complaints. How does it affect your life? What have you done about it? How have you treated it until now?

ORIGIN OF CAUSE: Can you trace the origin of the illness to any particular circumstance accident, medications, incident or mental upset such as shock or worry, errors in diet, overexertion, exposure to cold, heat etc.?

HOW TO DESCRIBE YOUR ADDITIONAL COMPLAINTS

In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homoeopathic physician "I have a headache ", "a rash"," a cough", “flu”, “a sinus infection” would not be enough. The information such as "I have sharp headache with throbbing pains in the left side of my head and temple. I am very sensitive to the slightest draft of cold air or when I enter an airconditioned room, it makes my head worse. I feel very drowsy, weak and can’t tolearte the pain in bright light.”, becomes very useful to choose an accurate homeopathic remedy. The success of the prescription depends, largely on how detailed is your description of the symptoms. You can use the following model for description.

LOCATION: Please give the exact location of complaint. Also describe where the pain or sensation spreads.

SENSATION: Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. Some factors include heat or cold, talking, laughing, sleeping, lying down, on right or left, sitting, standing, walking, eating, drinking etc.

DISCHARGES: You may have a discharge from ulcers, fistula, abscess, eruptions, the skin, lungs, eyes, nose, ears, mouth, vagina, etc. Please describe your discharge under the following aspects.

- The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases?
- The consistency: Is it thin or thick, stringy or clotted?
- Is it like jelly, white of an egg, like water, sticky forming a scab etc.?
- The odour, what does it remind you of?

Does it make the parts sore, in what way?

PAST HISTORY OF ILLNESSES:

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. It is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken. It not only helps in the choice of the homeopathic remedy but also helps to track all the symptoms. Homoeopathic treatment takes into account all these details of the past and facilitates the removal of all these weaknesses.

In the list below, circle around names of ALL illnesses so far suffered and on the next page give its relevant details.

<table>
<tr><td>Food Poisoning
Worms
Diarrhoea
Acidity/Ulcers
Backache
Sciatica</td><td>Measles
Rubella
Chicken-pox
Mumps
Whooping cough
Scarlatina</td><td>Malaria
Jaundice
Hepatitis
Colitis
Rheumatism
Herpes</td><td>Miscarriage. Abortion
Menopause related
Toxemic Pregnancy
Prolapse of uterus
Atypical Pap smear
Yeast Infections</td></tr>
<tr><td>Allergies
Ear Infections
Sinusitis
Asthma</td><td colspan="2">Sexually transmitted dis
Enlarged Prostate
Kidney or Bladder infections</td><td>Diabetes etc.
Thyroid Complaints
Osteoporosis
Blood Disorders</td></tr>
<tr><td>Recurrent infections – tonsillitis, Ear infections, Sinusitis, Bronchitis, Influenza, Pneumonia, Asthma</td><td colspan="2">Any operation such as Tonsils , Appendix , Hernia, Hemorrhoides, Uterus, Kidney Stone, Gall Stones, Phimosis , Hydrocele , Cataract, Teeth, Ceaserian Section, etc.
Mode of Anaesthesia: general or local</td><td>Any shock, grief, fright, depression, disappointments, panic attacks, or nervous break down</td></tr>
<tr><td>Chronic Headaches, Numbness, Cramps, Convulsions, Paralysis, Meningitis</td><td colspan="2">Any major accident or injury to body or head Any occasion of unconsciousness
Any major bleeding from any part of the body</td><td>Acne, Rosacea, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema, Psoriasis Etc.</td></tr>
</table>

Diseases suffered from	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Any extra remarks of information:

INFORMATION ABOUT HEALTH OF FAMILY MEMBERS:

List of major diseases		Relationship	Alive /dead	Age	Diseases	Cause of death
Anaemia Cancer Diabetes Insanity Rheumatism T. B. /Pleurisy Ulcerative Colitis Epilepsy/fits Bleeding tendency Urticaria Eczema Asthma Paralysis Hypertension Heart trouble Kidney disease Liver disease etc.		Paternal Grand Father				
		Paternal Grand Mother				
		Maternal Grand Father				
		Maternal Grand Mother				
		Father				
		Mother				
			Diseases Suffered			
		Paternal Uncles				
		Paternal Aunts				
		Maternal Uncles				
		Maternal Aunts				
		Cousin Brother & Sister on Father's side				
		Cousin Brother & Sister on Mother's side				
Did any of your relatives have trouble similar to yours						

SIBLING INFORMATION:

Provide information about your siblings and indicate your position by writing 'SELF'.

SR.NO	Brother /Sister	Alive /Dead	Age	Diseases suffered
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

INFORMATION ABOUT SPOUSE AND CHILDREN:

How is the health of your spouse? Please explain.

Mention ages of children and their condition of health. If any children died, please state causes:

Child's name	Male/Female	Age	Diseases Suffered

Have you had any abortions, miscarriages or still birth? What was the identified cause?

INFORMATION ABOUT YOU AS AN INDIVIDUAL:

PERSONAL HISTORY:

Birth History:

Did your mother have any problem during pregnancy?

Did she take any medications during pregnancy? What were they?

Was there any difficulty during your birth? Give details.

Milestones:

Teething		Urine control, Bed wetting etc.	
Sitting		Stammering	
Standing		Eating indigestibles such as chalk, lime ,mud, pencil	
Walking			
Speaking		Any other problem about your growth & development	

Tick mark (X) if any animal bites such as:

	Dog		Spider		Bees		Snake		Scorpion		Jelly Fish

Did you take anti-rabies or anti –venom or any other treatment?

Vaccination:

Indicate number of times you were vaccinated for the following:

Small pox	DPT	Meningitis	Hepatitis
MMR	B.C.G.	Typhoid	Chicken Pox

Was there any reaction or particular trouble after any of above vaccinations?

PERSONAL HABBITS:

Your Habits	How much
Smoking	
Snuff	
Chewing Tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives /Purgatives	
Recreational Drugs	

Reactions to different foods:

Please Put one tick (X) if you Like / Dislike the food or if the food disagrees. Put two tick mark(3 3) if you strongly Like / Dislike the food or if the food strongly disagrees.

	Like	Dislike	Disagrees			Like	Dislike	Disagrees
Bitter					Eggs			
Salt extra					Spicy food			
Sweet					Meat			
Sour					Fish			
Bread					Cabbages			
Butter					Onions			
Fats					Warm food/drink			
Milk					Cold food/drink			
Coffee					Fruits			
Mud/chalk								

APPETITE AND THIRST:

How is your appetite?

When are you hungry?

What happens if you have to remain hungry for long?

How fast do you eat?

How much thirst do you have?

Any particular times are you especially thirsty?

Do you feel any change in your taste and feeling in your mouth?

BOWEL MOVEMENTS:

Do you have any problem with your bowel movements? Explain.

When and how many times a day do you pass BM?

Any history of diarrhoea, constipation or irritable bowel symptoms?

Do you experience any urgency or incontinence?

Do you have to strain for stool? Even for soft stool?

Do you burp or pass gas excessively? Describe its character.

Does burping or passing gas relieve?

URINATION & URINE:

Are there any problems with your urination regarding frequency and character of urine? Explain.

Any unusual smell or color?

Do you have any trouble before, during and after urination?

Do you experience any difficulty with the flow such as slow to start, interrupted, dribbling etc.?

Is there any urinary incontinence or bed wetting or history of either? When?

SWEAT-FEVER-CHILL:

How much do you sweat?

What parts of your body are prone to sweating?

Do you sweat on palms, soles, nose, upper lip?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?

Is there any peculiar odor such as foul, pungent, sour, urine?

Does it stain the clothes, if yes, what color?

Are the stains easily washed off?

Do you experience any symptoms after sweating?

When do you get fever or chill? What brings it on?

Do you experience any sense of heat or cold in any part of your body at any particular time?

CHEST-HEART – COLD – COUGH

Do you catch cold often?

Describe the symptoms, nature of discharge etc.

Is there any trouble with your CHEST or HEART? Explain.

Is there any trouble with your voice or speech? Explain.

Is there any difficulty in breathing?

Do you have a cough?

Is it aggravated at any particular time?

SEXUAL SPHERE (GENERAL):

Have you had any excessive indulgence in sex or masturbation in past and present? Has it produced any ill-effect on your health? Explain.

Any particular feeling or symptoms appear before, during and after sexual intercourse?

Did you suffer from any sexually transmitted diseases?

Do you have unusually increased or decreased desire for sex?

What is the method you use for family planning?

FOR MEN:

Do you experience any difficulty in erection? Explain.

Are there any other troubles such as impotency or sterilty?

FOR WOMEN:

Menses:

How are the menstrual cycles- iregular or irregular?

At what age did the first menses start?

Was there any trouble then? Explain.

Mention number of days of flow.

Menstrual flow:

Have you noticed any variation in quality, quantity, color, smell, or consistency of flow during menses?

Are the stains difficult to wash?

Do you suffer in any way before, during or after menses? If so, describe:

What symptoms did you suffer during menopause?

Do you feel the internal parts coming down?

Is there any vaginal discharge? If so, describe the nature, colour, consistency & smell of discharge.

Does it produce any itching or rash or cracks?

Does the discharge increase or decrease in relation to menstrual cycle?

What is the effect of this discharge on your general feeling?

Do you pass any gas from vagina?

Have you had any trouble with your breasts?

GENERAL COMPLAINTS:

VERTIGO- Do you experience any dizziness or vertigo? Explain.

FAINTNESS: Do you ever feel faint?

HEAD: Do you get headaches or migraines? Have you had them in the past? Describe.

EYES & Vision: Describe.

EARS & sense of hearing:

NOSE & sense of smell:

FACE & Facial expression:

MOUTH & sense of taste:

TEETH, GUMS:

LIPS: cracked, peeling of skin etc.?

THROAT (including tonsils): Any difficulty in swallowing or post nasal drip?

BACK, LIMBS OR JOINTS: Describe in detail.

PAIN: If you have any pains, do they shift? In what direction do they extend?

SKIN: such as itching, eruptions, ulcers, warts, corns, peeling, psoriasis etc.? Describe.

Any change in colour of the skin or spots on any part of the body?

Do wounds heal slowly? Do wounds tend to form pus? Form keloid?

NAILS: Is there any complaint or abnormality of the NAILS or skin around?

HAIR: (falling, graying, dandruff, dryness, oily, poor excessive or unusual growth)

BLOOD: Do you have any tendency to bleed or bruise?

SIDES: Are your troubles one sided? Which side? Do they proceed from one to the other side? Or do they alternate or shift?

TREMORS/TREMBLING/JERKING/TWITCHES: If so, When?

WEAKNESS: Is there any sense of weakness?

When is it more or less?

Is it in any particular part of the body?

FACTORS THAT AFFECT YOU

Below you will find a list of things that you are exposed to. Each of these factors may affect you in a particular way. Do you feel worse or better in any way from each of the factors? Please write in what way you are affected by each of the following.

For example, write headache against sun, if you get headaches while under sun, Uneasy against hot weather, if you become uneasy in heat, asthma gets worse by lying down, write against lying down, asthma worse. Sometimes one factor may make you feel worse in some respect, and better in some other respect, For instance cold air may cause headache but headache but make you feel better in general. If this is so, please mention this difference clearly.

	Effect			Effect
Hot weather			Walking	
Cold weather			Running	
Rainy weather			Climbing stairs	
Cloudy weather			Going downstairs	
Change of season			Riding in bus, car etc.	
Thunder –storm			Lying	
Covering			Lying on back	
Warm bath			Lying on left side	
Sun			Lying on right side	
Cold bathing			Lying on abdomen	
Lying with head low			Burping or passing gas	
Sitting			Drinking	
Sitting erect			Dust	
Standing			Smoke	
Looking up			Touch	

Looking down			Pressure	
Looking from high places			Massage	
Looking at moving object			Tight clothes	
Noise			Before sleep	
Sudden noise			During sleep	
Music			After sleep	
Light			After afternoon nap	
Strong smells			Loss of sleep	
When constipated			Before stools	
Before urine			During stools	
During urine			After stools	
After urine			Coughing	
Before menses			Sneezing	
During menses			Laughing	
After menses			Talking	
After Sweating			Reading	
When Fasting			Writing	
After eating			Stooping	
Before an important engagement			After intercourse	
Before exams			After hair cut	
When angry			Combing hair	
When worried			Brushing teeth	
When sad			Moonlight	

After weeping			Opening the mouth	
Consolation			Smoking	
In a crowd			Hanging the limbs	
In a closed room			Hanging the arms	
Thinking of illness			Near sea	
Full / new moon			Shaving	
Morning			Stretching	
Afternoon			Swallowing	
Evening			Listening others talk	
Night			Vomiting	
Bathing			Yawning	
Draft air			Moving the eyes	
Biting or chewing			Opening the eyes	
Blowing nose			Closing the eyes	
When alone			Getting feet wet	
In company			Over eating	
Physical exertion			Working in water	
Belching			Fanning	

EMOTIONAL MAKE-UP & STATE OF MIND:

It is established that all illnesses have an emotional component. It does not mean that mind is the seat of disease or is the cause of all diseases. It merely means that both mind and body are affected in their indidividual ways and express their discomfort in any given stressful situation. For instance, one can become irritable or depressed with a fractured leg and emotional breakdown can trigger a progression of physical pathologies. We are more than just the parts. Treated as a whole, the unit has a tremendous potential to experience the sense of whole being. Homeopathic treatment is about bringing harmony to the individual as a whole.

In order to treat you as a whole and provide precisely accurate homeopathic treatment, it is necessary for us to understand your emotional and intellectual nature in addition to the physical characteristics. Please answer the following questions frankly without any hesitation.

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Do you get anxious? What circumstances make you anxious? Have you had any situations of panic?

Are you fearful of anything such as animals, people, being alone, darkness, death, diseases, robbers, sudden noises, thunder, of the future, of something unknown, high places, doctors, examinations, etc.? What symptoms do you experience?

Any phobias – claustrophobia, agorophobia, heights, flying?

Are you doubtful or suspicious of anyone or anything?

What are you jealous about? Do you experience any symptoms from jealousy?

In which matters are you impatient or hurried?

How long do you remember hurts caused to you by others?

Do you take revenge or contemplate it?

What are you proud of? Does your pride get easily hurt?

Depressed, Brooding, Mood Swings, etc.? Describe in detail.

Do you ever become suicidal? When?

If so in what manner do you contemplate to end your life?

Have you made any attempts or contemplated? How?

When are you most cheerful?

Any unwanted thoughts any time? What are they?

Do you experience any strange and unexplainable sensations or hearing voices?

How is your memory? For what is it poor? e.g. names, places, faces, what you have read, etc.

Do you cry or become emotional easily? What makes you cry?

How do you feel after crying?

How do you feel if someone offers sympathy and consolation?

Are you easily irritated? What triggers your anger?

What bodily symptoms do you develop when angry or irritated such as trembling, sweating, loosing voice, weakness etc.?

Do you prefer to be alone or with company?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What are the greatest griefs that you have gone through in your life? What effects did they have on you?

What are the greatest joys that you have had in life?

What activities you deeply enjoy, hobbies?

Are there any matters which you deeply dislike?

In your opinion, which aspects of youself, your personality or moods are not agreeable to you? Inspite of your awareness and maturity, are you unable to change these aspects?

Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.

How does the future look to you?

Are you worried or unhappy over any and personal, domestic, economical, social or any other condition? If so describe in detail:

S L E E P

Describe your posture in sleep. On the back, side, abdomen etc.

Are you able to sleep in any position? If not, in which position you can't sleep?

During sleep do you: Snore? Grind teeth? Dribble saliva? Sweat? Keep eyes or mouth open? Walk? Talk? Moan? Weep? Become restless? Wake up with a jerk?

Describe if anything else is unusual about your sleep: (drowsiness, insominia, interrupted sleep) If so when and what helps?

How much do you cover? Do you have to uncover any parts?

DREAMS:

Dreams are very important for choosing the correct homeopathic remedy, please circle the dreams that you have had. Describe in detail those that created an impression on your mind. Also, describe the reoccuring dreams in detail.

Animal Cats-dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming drowning	Houses Fruits Trees Water Snow	Death, Whose? Dead bodies Dead person Parts of Body Suicide
Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasure	Business Money Day's work Forgotten work
Vomiting Passing stool Urinating Blood – bleeding Bathrooms	Romantic Sexual pleasure Rape Nakedness	Pain Illness Sickness Misfortunes Danger	Praying Religious Temple Church God	Failure /exams Unsuccessful efforts for Missing train Being unprepared Pursued – whom, for what?
Grief Weeping Vexation, Insults Quarrels Jealousy Insecurity	Police Imprisonment Crime Murder Killing Poison	Of people Children Parties Feasts Marriage	Of events Remote Recent Future Prophetic	Physical Exertion Mental Exertion Fatigue Coloured Multi-Coloured

FOR CHILDREN or YOU AS A CHILD:

1) Please mark (X) if the child or you as child had any of the following qualities, mark (XX) if they are more intense:

	Mark		Mark
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Religious	
Hyperactivity		Biting nails	
Destructiveness		Thumb –sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition-winning spirit		(b)shawls , handkerchieves	
Sibling jealousy		(c) anything else	
Boasting		(d) genitals	
Stealing		Dullness of memory	
Telling lies		Slowness	
Sensitive/Emotional		Laziness /Indolence	

2) Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also describe the dreams the mother got during pregnancy.

3) Please describe your nature as a child or your child's nature in detail.

4) Describe one incident from the child's life when he/she was very upset.