

## **HOMOEOPATHIC CASE RECORD FORM**

**(FOR ADULT)**

### **PLEASE READ THIS FIRST BEFORE FILLING THE FORM**

All our efforts will be concentrated towards selecting the best possible medicine for you. In order to do that, we depend on your co-operation. Homoeopathic medicine is mainly selected on the symptoms you give us. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental makeup. This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person. In order to find out all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is of lesser importance. Even something that you may think is not connected with your trouble may be the most important factor in deciding the correct homoeopathic medicine. That is why you must be free and frank and give us the fullest possible information on each point. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential. We reserve the right to use this information provided by you for our in-house research or statistical purpose.

#### **THIS QUESTIONNAIRE HAS 7 PARTS**

1. Description of your main complaint / complaints.
2. About your past illnesses, vaccination details and the developmental history. It also includes details on medical history of family members. Please take time to answer this part, preferably taking the help of your family members.
3. Personal history that covers all your allergies and addictions, likes, dislikes, etc.
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.
5. 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. Be totally frank and open.
6. How you were as a child.
7. Parts of the body affected.

#### **Please attach with this form:**

1. All your medical reports and opinion on your state of health from physician.
2. Recent copies of investigations done, e.g. C.B.C., ESR, U.S.G, X-ray plates, electrocardiograms, etc.
3. Please mention if you have taken any homoeopathic medicines. Brief us with the name of the medicine you have received along with response to the same (if you are aware of).

# CONFIDENTIAL

Date :

Name : \_\_\_\_\_  
(Begin with Surname)

Date of Birth :

Age :

Sex: Male / Female

Address :

Telephone (R) :

Mobile :

E-mail :

Religion :

Diet : Veg. / Non veg.

Marital status : Single / Married / Divorced / Widowed.

Education :

Occupation (Nature of work) :

Address of work place :

Telephone (W) :

E-mail :

Nationality :

Language spoken :

Referred to us by :

## DETAILS OF PRESENT ILLNESS

In Homoeopathy, prescription is based on precise details of various symptoms from which you suffer. The mere mention of a complaint does not suffice for a good prescription. Please follow the instructions given below for helping us understand your complaints.

Remember, the success of the prescription depends, largely, on how detailed is the description of your symptoms. We require the following details about your symptoms.

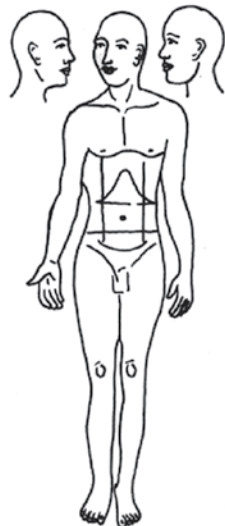
What are your complaints?

Since when are you having the complaints?

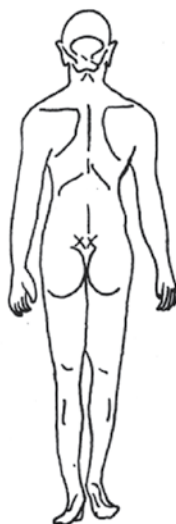
**Location:** Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads.

**PLEASE MARK THE LOCATIONS OF YOUR TROUBLE IN THE BELOW**

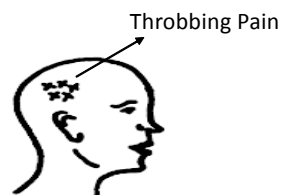
RIGHT FACE      FRONT      LEFT FACE



BACK



(You can also mark other parts of the body which are affected, by writing the complaint next to each, e.g. head → pain.)



**Sensation:** Express the type of sensation or the pain that you get in your own words. Express the sensation or pain as it feels to you.

**Origin of cause:** Can you trace the origin of the present illness to any particular circumstance, mental upset, illness, incident or accident? (E.g. shock, worry, errors in diet, overexertion, overexposure to cold, heat, etc.)

What are the factors that influence your trouble? E.g. weather, food, pressure, anxiety, etc. or any other (Please refer to part 4 on page 19 and 20 for a detailed list of the factors).

Please mention how each factor affects you, whether it increases or decreases your complaint, and also how much does it affect your complaint. E.g. headache worse by even little exposure to sun, headache better by pressing the head.

For complaints other than the main complaint, please fill the details in the table given below.

Sr. no.	Where is the trouble?	What exactly do you feel or have there?	What are the factors that make this trouble better or worse?	Any complaint or symptom associated with this complaint.

PAST AND FAMILY HISTORY

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, affecting us much more than we imagine. Homeopathic treatment takes into account all these details of the past and thus removes all weak points. Your body is strengthened. It is therefore necessary for us to know about all the ailments you have suffered from in the past and treatments you have taken. In the list below, circle the names of ALL major illnesses suffered so far and on the next page give their relevant details.

<p>Typhoid Cholera Food poisoning Worms Diarrhea Dysentery</p>	<p>Measles German measles Chicken-pox Small-pox Mumps Whooping cough</p>	<p>Malaria Jaundice Any liver, spleen or gall bladder disease</p>	<p>Miscarriage Abortion Curetting Sickness during pregnancy, etc. Prolapsed of uterus</p>
<p>Malnutrition Rickets Rheumatism Backache</p>	<p>Any venereal diseases like Syphilis, Gonorrhoea, etc.</p>	<p>Any heart trouble, blood pressure, giddiness</p>	<p>Nephritis (Kidney or urine trouble) Diabetes, etc. Prostate trouble</p>
<p>Any operation such as for Tonsils, Abdomen, Appendix, Hernia, Piles, Uterus, Renal stones, Gall stones, Phimosis, Hydrocoele, Cataract, etc. Mode of anesthesia : general / local</p>	<p>Diphtheria, Tonsillitis, Adenoids Recurrent infections - Sinusitis Bronchitis-Eosinophilia Cold – fever- chill Asthma – Pleurisy – T.B.</p>	<p>Any major accident or injury to body or head. Any occasion of unconsciousness. Any major bleeding from any part of the body.</p>	<p>Any serious shock, grief, disappointments, fright, mental upset, depression or nervous breakdown</p>
<p>Chronic headaches, numbness, cramps, fit, convulsions, paralysis, etc. Polio, Meningitis- any lumbar puncture done.</p>	<p>Skin diseases like pimples, boils, carbuncles, ringworms, fungus, scabies, eczema, psoriasis, Herpes, urticaria, allergy on any part of the body.</p>		

**DETAILS OF YOUR PAST ILLNESS**

Sr. no.	Diseases suffered from	Age (approx.)	Duration	Medication taken	Fully recovered or not	Any other particulars

Mention any drugs, tonics, stimulants, etc. that have been used by you at any time in life.

**FAMILY HISTORY**

Please fill in the table given below after reading the list given.

List of major diseases – Anaemia, Cancer, Diabetes, Insanity, Rheumatism, T.B./ Pleurisy, Leprosy, Epilepsy / Fits, Bleeding tendency, Urticaria, Eczema, Asthma, Paralysis, Hypertension, Heart trouble, Kidney disease, Liver disease, etc.

Relationship	Alive / Dead	Age	Disease suffered	Disease suffering from since when	Cause of death
Paternal grandfather					
Paternal grandmother					
Maternal grandfather					
Maternal grandmother					
Father					
Mother					
Brother(s)					
Sister(s)					
Paternal uncle					
Paternal aunt					
Maternal uncle					
Maternal aunt					
Cousin brother & sister on father's side					
Cousin brother & sister on mother's side					
Did any of your relatives have trouble similar to yours					

(If married) how is the health of your husband / wife?



Number of children : Living or dead. If dead, state the cause for the same. Mention the ages of children and the condition of their health.

Sr. no.	Child's name	Age	Male / Female	Disease suffered

**DEVELOPMENTAL HISTORY**

Milestone	At what age did you start	Problems
Teething		
Sitting		
Standing		
Walking with support		
Walking without support		
Speaking		
Urine control		

Were there any other problems in your growth & development?

VACCINATION HISTORY

Sr. no.	Vaccine given	Age	Complaints after vaccination	Duration (for how long did they last)	Any other details
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Any thing else you would like to mention.

## **PERSONAL HISTORY**

### **ALLERGY HISTORY**

Do you suffer from any allergic conditions, please specify.

If any specific allergen testing is done, then please mention and attach your investigation reports.

### **ADDICTIONS**

Which substances are you addicted to - like, alcohol or any other beverages, internet, shopping, any drug substances like smoking, tobacco, supari, pan, cannabis, alcohol, LSD, marijuana, cocaine, etc.?

### **APPETITE AND THIRST**

How is your appetite?

When are you hungry?

What happens if you have to remain hungry for long?

Do you have a habit of eating fast?

How much thirst do you have?

How frequently do you drink and how much?

Please put one plus mark (+) if you Like / Dislike the food or if the food disagrees. Put two plus marks (+ +), if you strongly Like / Dislike the food or if the food strongly disagrees.

Please mention any other specific food items or drink that you really crave or like, at bottom.

Foods	Like	Dislike	Disagree	Foods	Like	Dislike	Disagree
Salty				Cabbage			
Bitter				Onion			
Spicy				Tea			
Sour				Coffee			
Sweet				Milk			
Exotic				Curds			
Bread				Fruits			
Butter				Warm food			
Cheese				Cold food			
Eggs				Ice			
Chicken				Ice-cream			
Red meat				Any other			
Pork							
Fish							
Fatty food / Fried food							

**URINE**

Any problem in urination?

Any strong smell of urine? What is it like?

Any difficulty in the flow? Slow to start, interrupted, feeble, dribbling, etc.?

**STOOL**

Do you have any problem regarding your stools?

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

Are you satisfied after passing stools?

When is it urgent?

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

**SWEAT / PERSPIRATION**

How much do you sweat?

On which part do you sweat the most?

Does the sweat smell? What is the kind of smell?

Does the sweat stain the clothes? What color?

Any complaints after sweating?

Do you perspire on the palms or soles?

**FEVER - CHILL**

When do you get fever or chill?

What brings it on?

With fever, which part feels hot?

With chills, which part feels cold?

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

Do you have burning or heat or cold feeling in your palms or soles?

**SLEEP**

Describe your posture in sleep. (e.g. on back, abdomen, sides) Are you uncomfortable in any position?

How is your sleep pattern?

During sleep do you grind / snore / dribble saliva / sweat / keep mouth open / walk / talk / moan / weep / become restless / wake up with a jerk, etc.?

Describe anything unusual about your sleep.

How much do you cover / uncover any parts?

## DREAMS

Circle types of dreams that you have:

Animals 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 persons Parts of body Suicide	Being hungry Being thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars
Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work	Vomiting Passing stool Urinating Blood-bleeding Excrements / soiling	Romantic Sexual pleasure Rape Nakedness
Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure / Exams Unsuccessful efforts- for what? Missing train Being unprepared	Grief Weeping Vexation Quarrels Jealousy Insults
Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - by whom? - for what?	Of people Children Parties Feasts Marriage	Of events Remote Recent Future Prophetic
Physical exertion / Mental exertion / Fatigue			

If any other, specify in the space below:

## **SEXUAL SPHERE**

How do you feel after sexual intercourse?

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

Any dislike or aversion for sexual intercourse?

Do you have increased or decreased desire for sex?

Do you masturbate? What is the frequency? What is its effect?

Do you suffer from any sexual disturbance?

Any excessive indulgence in sex in past and present?

Any homosexual inclination?

Did you suffer from any sexually transmitted disease, like Syphilis, Gonorrhoea, Herpes, H.I.V., etc.?

Any recurrent infections of the genital organs?

Which method do you use for family planning (contraception)?

## **FOR MEN**

Is there any difficulty in erection?

Do you suffer from weak erection, failing erection? Describe.



Is there any premature ejaculation?

Any complaints of nightfall or seminal emissions?

**FOR WOMEN**

Any dryness, itching, discomfort, bleeding, burning or pain in vagina before, during or after sexual intercourse?

Any pain in abdomen after intercourse?

**MENSTRUAL HISTORY**

At what age did your menses start?

How are the menses; regular or irregular?

Did you have any trouble?

How many days is your monthly cycle?

**MENSTRUAL FLOW**

Duration (days):

Quantity of flow (e.g. profuse, scanty, moderate):

Color of flow:

Smell if any from the flow:

Staining, if any (Color of the stains):

Are the stains difficult to wash?

Do you have any complaints before, during or after menses? If so, describe.

If menopausal, mention the age of menopause. Any complaints around that time?

Did you experience any symptoms during menopausal period?

Is there any white discharge?

If so, mention the nature, color, consistency and smell of discharge.

When and under what circumstances is it more or less?

Does the discharge have any relation to menses?

Any itching, burning, etc. due to discharge?

Do you pass gas from vagina?

Any trouble with breasts?

**OBSTETRICS HISTORY**  
**PREGNANCY DETAILS**

Number of times you have conceived:

Number of times your pregnancy reached at or above 7 months:

Any history of abortion / miscarriage? If yes, at what month of pregnancy? Reason for the same.

Any complaints during pregnancy, e.g. nausea, vomiting, etc?

Was there liking / disliking for, any food / drink during any pregnancy?

What was your mental state during pregnancy?

Any foetal abnormality detected during investigations?

### **DELIVERY**

How many times have you delivered?

Were your deliveries full term / early / delayed?

Were they normal deliveries?

Were they Caesarian section / forceps / vacuum delivery? Reason?

### **LACTATING HISTORY**

Did you breast feed? If yes, for how long?

Any complaints during that period?

After how much time of your delivery did you get menses again?

### FACTORS AFFECTING YOU

This section is the most important. Do not go through it hurriedly. Think carefully about the effect of each factor on the overall health and especially on the complaints (whether it increases / decreases or affects the complaint in any peculiar way) before you write:

E.g. for instance, take the factor 'Sun'. Suppose by going in the sun you get a headache, then write headache, then write 'headache' opposite to 'Sun'.

FACTORS	EFFECT
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunder storm	
Covering	
Warm bath	
Sun	
Fanning	
Air condition	
Cold bathing	
Riding in bus, car, etc.	
Lying	
Lying with head low	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	
Running	
Walking	
Climbing stairs	
Going downstairs	
Sitting	
Sitting erect	
Standing	
Looking up	
Looking down	
Looking from high places	
Looking at moving objects	

FACTORS	EFFECT
Noise	
Sudden noise	
Music	
Smell	
Strong smells	
Light	
Dust	
Smoke	
Light	
Touch	
Pressure	
Tight / loose clothes	
High places	
Narrow places	
Open air	
Draft of air	
When constipated	
Before urine	
During urine	
After urine	
Before menses	
During menses	
After menses	
After sweating	
When fasting	
After eating	
Drinking	
After sexual intercourse	
Dust	
Massage	
Before sleep	
During sleep	

FACTORS	EFFECT
After sleep	
After afternoon nap	
Loss of sleep	
Before stools	
During stools	
After stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After weeping	
Consolation / sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Full moon	
New moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	

FACTORS	EFFECT
Draft of air	
Biting / chewing	
Blowing nose	
When alone	
In company	
Physical exertion	
Belching	
Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Moonlight	
Opening the mouth	
Smoking	
Hanging the limbs	
Raising the arms	
Near sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Overeating	
Working in water	
Any others	

## MIND

In order to understand your emotional and intellectual nature, we will be asking certain questions. Answer them freely, carefully and completely. This information will help us in giving you the correct medicine. Also such a medicine will help improve your mental makeup.

*Answer freely. Answer frankly. Answer completely.*

1. Are you anxious? About which matters?
  
2. Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.?
  
3. Are you doubtful or suspicious? Of what?
  
4. What are you jealous about? Of whom? From what symptoms do you suffer when you get jealous?
  
5. Generally how would describe yourself as, slow / medium / fast pace?
  
6. How long do you remember hurts caused to you by others?
  
7. Are you revengeful?
  
8. What are you proud of? Does your pride get easily hurt?
  
9. Do you ever become suicidal? When? If so, in what manner do you contemplate to end your life? Even then, are you afraid of dying?
  
10. When are you cheerful?
  
11. Are you sexual-minded?

12. Any unwanted thoughts any time? What are they?
13. Have you any imaginary sensations or fears?
14. How is your memory? For what is it poor? E.g. names, places, faces, what you have read, etc.
15. Are you easily irritated?
16. What makes you angry? Do you get violent?
17. What bodily symptoms do you develop when angry? E.g. trembling, sweating, etc.
18. Do you like company? Or like to remain alone?
19. How seriously are you affected by disorder and uncleanliness in your surrounding?
20. What are the greatest grieves that you have gone through in your life?
21. What are the greatest joys that you have had in your life?
22. What activities you deeply like?
23. Are there any matters which you deeply dislike?

24. In your opinion, which aspect of your mind and moods are not agreeable to you, that in spite of your awareness and maturity, you are unable to change?

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

26. How does the future look to you?

27. When you are free, what thoughts come to your mind?

28. Are you worried or unhappy over any personal, domestic, economical, social or any other conditions? If so describe in detail.

29. What are your three wishes?

1.

2.

3.



## **CHILDHOOD**

1. Describe your nature as a child?
2. What were your fears as a child?
3. Any recurrent dreams in your childhood?
4. Any incident in your childhood that had a major effect on you?
5. Do you know of anything about your mother's history during pregnancy?

## **PARTS OF BODY AFFECTED**

### **ANY COMPLAINTS ABOUT**

**Vertigo:** Do you have giddiness or vertigo?

**Faintness:** Do you ever feel faint? When?

**Head:** Do you get headaches?

**Eyes & Vision:** e.g. redness, burning, difficulty in reading, etc.

**Ears & Sense of hearing:** e.g. ear pain, difficult hearing, etc.

**Nose & Sense of smell:** e.g. bleeding from the nose, any problem with smell, etc.

**Face & Facial expression:** e.g. acne, pigmentation, moles, warts, etc.

**Mouth:** e.g. ulcers, bad smell from mouth, etc.

**Teeth & Gums:** E.g. carious teeth, stained teeth, bleeding or swollen gums, etc.

**Tongue & Taste:** E.g. sense of taste, any cracks, coating, etc.

**Lips:** E.g. cracked, peeling of skin, etc.

**Throat** (including tonsils): E.g. pain, difficulty in swallowing, trouble with voice or speech, etc.

### **Cold & Cough**

Do you catch cold often? What factors generally bring on the cold?

Describe the symptoms during cold, nature of discharge from nose, etc.

Do you get cough? What brings on the cough?

Is it more at any particular time?

### **Breathing**

Any difficulty in breathing?

How frequent is it?

What brings it on or makes it worse / better?

**Back & Limbs**

Do you have any trouble in back, limbs or joints? Describe in detail.

If there are pains, do they extend in any direction or shift?

What brings on the pains or makes them worse / better?

Is there any abnormality, swelling, numbness, paralysis, etc. in any part of the body?

**Skin**

Do you have complaints like itching, eruptions, ulcers, warts, corns, peeling, change in color, spots, etc.? If yes, describe.

**Nails:** Is there any complaint or abnormality of the nails or the skin around?

**Hair:** Is there any complaint with the hair such as falling, graying, dandruff, dryness, oily, poor / excessive / unusual growth?

**General**

Do the wounds take a long time to heal?

Is there any tendency for formation of keloids or pus?

Do you have a tendency to bleed?

Is there any trembling? When?

Is there any sense of weakness? Where?

When is it more and what causes it?

**Please draw / color something which comes to your mind spontaneously at this very moment.  
Or something that you draw / doodle repetitively.**

**Would you like to mention any other aspect of yourself, which is not covered in the questionnaire?**

**Kindly let us know what was your experience while filling this form.**