HOMEOPATHIC CASE TAKING FORM

AVAILABLE AT

Dr. Dwivedi's

KHUSHI CLINIC

&

HOMEOPATHY RESEARCH CENTER

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Dr. Dwivedi's

KHUSHI CLINIC & HOMEOPATHY RESEARCH CENTER

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

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 find 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 useless. 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.

THIS QUESTIONNAIRE HAS SEVERAL PARTS:

1. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.

2. History of your present illness.

3. 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.

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. About your sleep and dreams.

7. For children or how you were as a child.

8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

Founder of Homeopathy

Christian Friedrich Samuel Hahnemann

(10 April 1755 – 2 July 1843)

All information given is kept confidential

CASE RECORD

Confidential		DATE	
NAME			
AGE		**SEX**	
MARITAL STATUS			
FATHER'/HUSBAND'S NAME			
TELEPHONE			
WORK PLACE/JOB			
E-MAIL			
ADDRESS			
DIAGNOSIS			
REFFERD BY			

Any other Information to share

All information given is kept confidential

Please describe your complaints. Giving Details on when it began, how it has progressed. Please mention factors that increase or decrease discomforts.
RECORD PROBLEMS IN CHRONOLOGICAL ORDER (Earliest in the beginning and latest at the end)

Summary of tests, evaluations done	
Tests	**Results**

Please mention other therapies the patient is on, include the therapists name, from when the therapy began and changes that you have noted since.		
RECORD IN CHRONOLOGICAL ORDER (Earliest in the beginning and latest at the end)		
S.no	**Date**	**Therapy (** Allopathic/Ayurvedic/Homeopathic/Others **)**

Please mention the names and dosage of medicine and supplements that you are on now or have taken in the past	
Medicine	**Doses/Type**

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Past History

Every disease, poisoning, drug or accident leaves its mark and remains a weak point in the system, much more than we imagine. Homeopathic treatment takes into account all the details of the past and thus removes all the weak points. Thus your body is strengthened. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatment you have taken.

In the list below underline the names of all major illnesses so far suffered

Adenoids Allergy. Any Major Accident Any major bleeding Appendix, Asthma	Backache Bronchitis Carbuncles Chicken-pox Cholera Cataract Cold-Fever-Chill,	Diabetes mellitus Diarrhea Diabetes insipidus Diphtheria Dysentery	Eczema, Eosinophilia Food poisoning Fungus, gall bladder disease Giddiness
Heart trouble Herpes, High/Low B.P Hydrocele	Injury to body or head. Jaundice Kidney affection liver, spleen disease	Malaria Malnutrition Measles Menstrual complaints, Mumps	Piles, Phimosis, Pimples, boils, Pneumonia Prolapse of uterus Prostrate trouble
Rheumatism Rickets Ringworm,	Scabies Sinusitis Skin diseases Septic, Small-pox Stones (kidney, gall bladder) Syphilis, Gonorrhea	Tuberculosis, Tonsils, Urticaria Ulcers on any venereal disease	**Any Other Diseases** *Mention it below*

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

Any extra remarks or information

All information given is kept confidential

List of major diseases	*Relationship*	*Alive / Dead*	*Age*	*Diseases suffered*
Anemia **Cancer** **Diabetes** **Insanity** **Arthritis** **Rheumatism** **T. B. / Pleurisy** **Leprosy** **Epilepsy / Fits** **Bleeding tendency** **Urticaria** **Eczema** **Asthma** **Paralysis** **Thyroids** **Hypertension** **Heart trouble** **Kidney disease** **Liver disease etc.** **Vitiligo** **Other Diseases**	Paternal Grand Father			
	Paternal Grand Mother			
	Maternal Grand Father			
	Maternal Grand Mother			
	Father			
	Mother			
	Brothers			
	Sisters			
	Paternal Uncle/ Aunts			
	Maternal Uncle/Aunts			
	Cousin Brother & Sister			
	Did any of your relatives have trouble similar to yours			

INFORMATION ABOUT SPOUSE AND CHILDREN

How is the health of your spouse? Please explain.

Mention ages of children and their condition of health

Child's name Male/Female	**Age**	**Diseases Suffered**

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

All information given is kept confidential

PERSONAL HABBITS

Your Habits	How much?
Smoking	
Snuff	
Chewing tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives / Purgatives	
Recreational Drugs	
Any other	

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?

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

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Bitter				Eggs			
Salt				Spicy food			
Sweet				Meat			
Sour				Fish			
Bread				Cabbage			
Butter				Onions			
Fats				Warm food / drink			
Milk				Cold food / drink			
Coffee				Fruits			
Mud / Chalk				Anything else			

STOOL

Do you have any problem regarding your stools?

When and how many times a day you pass stools?

When is it urgent?

Do you have any problem about bowel movements?

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

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas up or down?

URINATION & URINE

Any problem about urine?

Any strong smell? Like what?

Do you have any trouble before, during and after passing urine?

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

Any involuntary urination? When?

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat?

Where and on what part do you sweat most?

Do you perspire on the palms or soles?

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

What is the smell like? E.g. foul, pungent, sour, urinous.

What color does it stain the clothing?

Is the stain easy to wash off or difficult?

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 ?

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

CHEST - HEAT - COLD - COUGH

Do you catch cold often? If so, how?

Describe the symptoms, nature of discharge etc.

Is there any trouble with your CHEST or HEART?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

Do you have cough?

Is it more at any particular time?

SEXUAL SPHERE (GENERAL)

Any excessive indulgence in sex in past and present?

Any effect on your health?

How do you feel after sexual intercourse?

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

Do you suffer from any sexual disturbance?

Any habit like (masturbation etc.) in past as well as present? How often?

Any homosexual inclination?

Did you suffer from any sexually transmitted disease?

Syphilis? Gonorrhea? Herpes? HIV?

Did you have increased desire or decreased desire for sex?

What is the method you use for family planning (contraception)?

FOR MEN

Any difficulty in erection?

Wanted erection? Unwanted erection?

Weak erection? Failing erection? Describe.

Any other trouble in sex? Describe in details.

FOR WOMEN

Menses: How are the periods; regular or irregular?

At what age did you start?

Was there any trouble then?

Mention interval between two periods.

Mention number of days of flow.

Menstrual flow: Is there any change now in quantity,

Color, smell or consistency?

Are the stains difficult to wash?

Have you noticed any variation in quality?

and quantity of flow during menses ? How and when?

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

What symptoms did you suffer during menopause?

Do you feel internal parts coming down?

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?

Has the discharge any relation to menses?

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

Any itching, excoriation etc. due to discharge?

Any trouble with breasts?

ANY COMPLAINTS ABOUT:

VERTIGO - Do you have giddiness - vertigo?

Faintness: Do you ever feel faint?

HEAD: Do you get headaches?

EYES & VISION:

EARS & Sense of hearing:

NOSE & Sense of smell:

FACE & Facial expression:

MOUTH & Sense of taste:

About LIPS, MOUTH, TONGUE etc.:

TEETH, GUMS, e.g. carious teeth, bleeding/swollen gums.

LIPS: Cracked, peeling of skin etc.

THROAT (including tonsils):

Any difficulty in swallowing?

Do you have any trouble in your BACK, LIMBS OR JOINTS?

Describe in detail:

If you have pains, do they shift?

In what direction do they extend?

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

FACTORS THAT AFFECT YOU

Below are the list of things that you are exposed to each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of the factors? In what way do they affect you? For instance take the factor “sun”. Suppose by going in the sun you get a headache then write “Headache” opposite to “Sun”. Take another example if in hot weather you feel uneasy, and then write “Uneasy” opposite to “Hot Weather” in the column. In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes 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 make you feel better in general. If this is so, please mention this difference clearly. This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

	Effect		**Effect**		**Effect**
Hot weather		Walking		Noise	
Cold weather		Running		Sudden Noise	
Rainy weather		Climbing stairs		Music	
CloudyWeather		Going downstairs		Light	
Change of season		Riding in bus, car		Strong smells	
Thunder storm		Lying			
Covering		Lying on back		Before Urine	
Warm bath		Lying on left side		During Urine	
Sun		Lying on right side		After Urine	
Drinking		Lying with head low		Before Menses	
Sitting		After sexual intercourse		During Menses	
Sitting erect		Dust		After Menses	
Standing		Smoke		Before important meeting	
Looking up		Touch		Before exams	
Looking down		Pressure		When angry	
Looking from high places		Massage		When worried	
Looking from moving object		Tight Clothes		When sad	
When Fasting		After Sweating		After Weeping	
After eating		In constipation		Consolation / Sympathy	
In a crowd		Before Sleep		Over eating	
In a closed room		During Sleep		Working in water	
When thinking of illness		After Sleep		Fanning	
Full Moon / New Moon		After afternoon nap		Hanging the limbs	
Morning		Loss of sleep		Arms raising	
Afternoon		Before stools		Near Sea	
Evening		During stools		Shaving	
Night		After stools		Stretching	
Bathing		Coughing		Swallowing	
Draft air		Sneezing		Listening to others talk	
Biting or chewing		Laughing		Moonlight	
Blowing Nose		Talking		Moving the eyes	

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When alone		Reading		Opening the eyes	
In company		Writing		Closing the eyes	
Physical exertion		Stooping		Getting feet wet	
Belching		Passing gas		Brushing teeth	
Vomiting		After hair cut		Opening the mouth	
Yawning		Combing hair		Smoking	

Any other factors which Effects you					

All information given is kept confidential

MIND

It is now universally acknowledged that your mind has tremendous influence on our body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole. In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental makeup.

Answer freely. Answer frankly. Answer completely.

Are you anxious? About which matters?
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.?
Are you doubtful or suspicious? Of what?
What are you jealous about?
Of whom? From what symptoms do you suffer when jealousy?
In which matter are you impatient? Hurried?
How long do you remember hurts caused to you by others?
How much revengeful are you?
What are you proud of? Does your pride get easily hurt?
Depress, Brooding, etc.?
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?
When are you cheerful?
Any unwanted thoughts any time? What are they?
Have you any imaginary sensations or fears ?
Do you hear voices, or that you are called, or anything else in this line keeps on occurring in your mind

unduly ?
How is your memory ? For what is it poor? e.g. names, places, faces, what you have read, etc.
Do you weep easily ? What makes you weep ?
How do you feel after weeping ?
How do you feel if someone offers sympathy and consolation ?
Are you easily irritated ?
What makes you angry ?
What bodily symptoms do you develop when angry ? e.g. trembling, sweating etc.
Do you like company ? Or like to remain alone ?
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 are the greatest joys that you have had in life?
What activities you deeply like?
Are there any matters which you deeply dislike?
In your opinion, which aspects of your mind and 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?
When you are free, what thoughts come to your mind?
Are you worried or unhappy over? Any personal, domestic, economical, Social or any other condition? If so describe in detail:

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If asked for 3 desires or wishes in life, what will you ask for?
1
2
3

S L E E P

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

Are you able to sleep in any position?

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: (Sleepy, Sleeplessness, etc. if so when)

How much do you cover?

Do you have to uncover any parts?

FOR CHILDREN
Or
YOU AS A CHILD (IN CASE OF ADULT)

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.

Please describe any other aspects you feel are striking about the child.

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

Other Important details you want to share:

HOW TO DESCRIBE YOUR COMPLAINTS (For Patients)

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", "an eruption", or "cough", would not be enough. If you inform him "I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool", then only you have given all the information required for making a good homoeopathic prescription.

The success of the prescription depends, largely, on how detailed is your description of the symptoms.

We require the following details about your symptoms.

LOCATION:

_____

Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on page below to indicate location.

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. A detailed list of the factors is given on pages 14 to 16. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

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

***** The quantity and the time or condition under which the quantity varies i.e. when it is better or worse, increases or decreases?

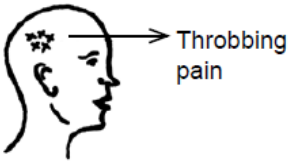
***** The consistency; Is it thin or thick, stringy, or clotted?

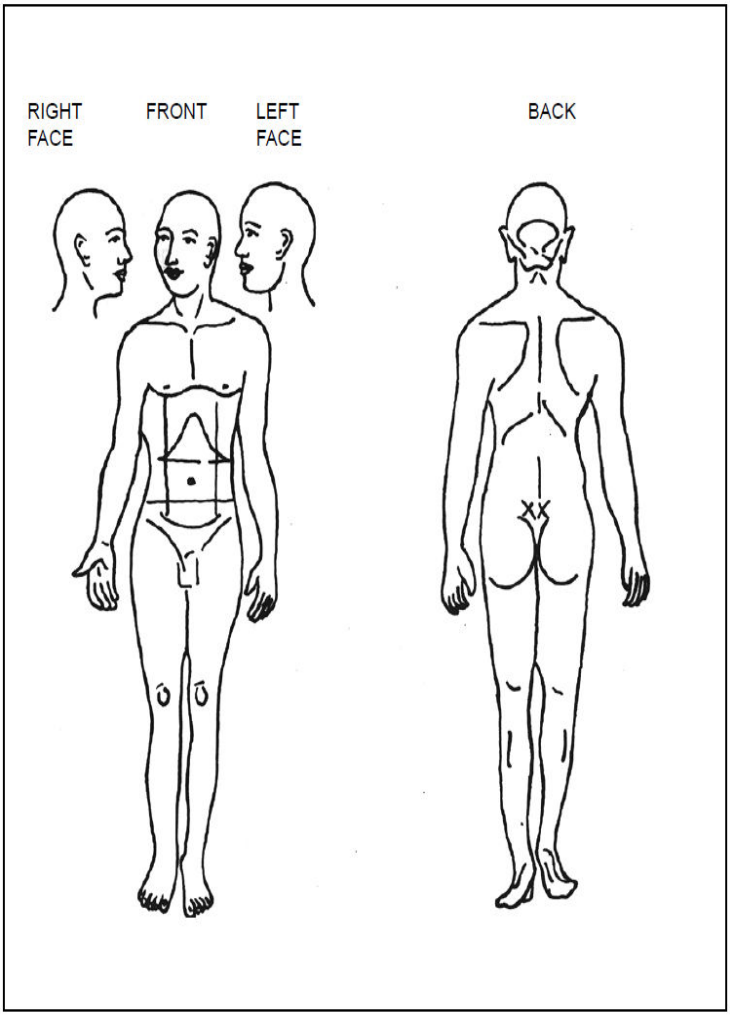
***** Is it like jelly, white of an egg, like water, sticky, forming a scab etc.?

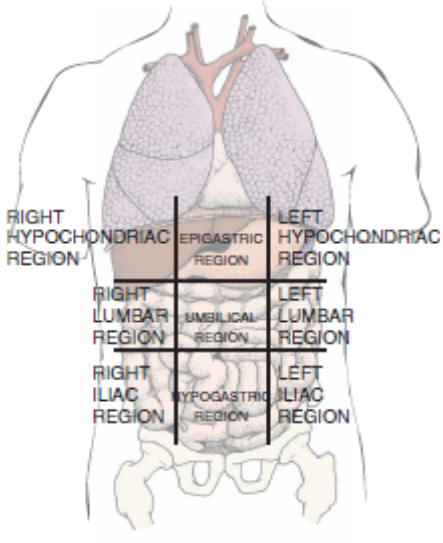
***** The odour, what does it remind you of?

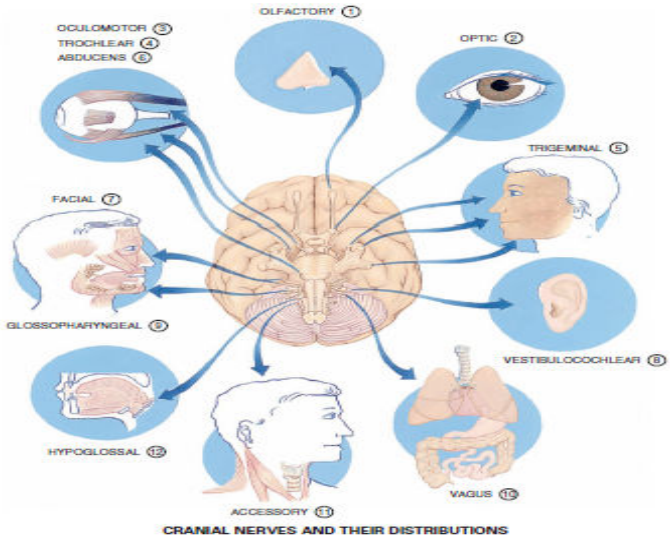
***** Does it make the parts sore, and in what way?

Please mark in the below figure, the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of you head please mark as shown









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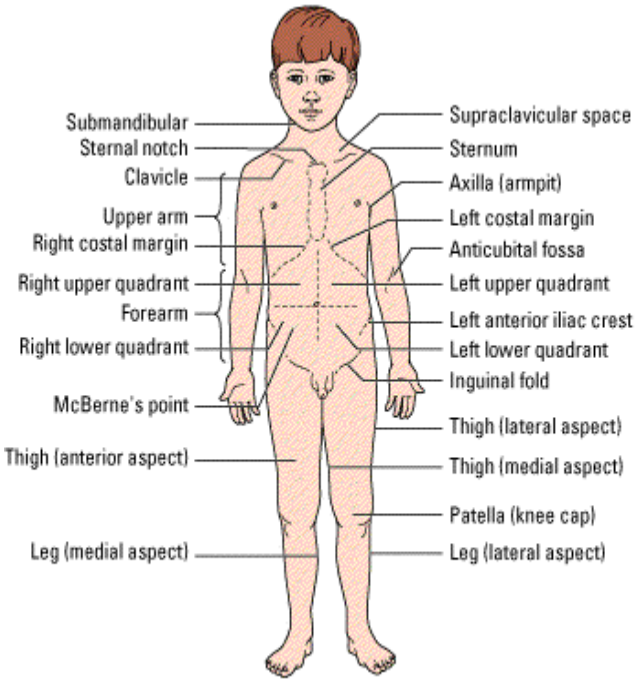
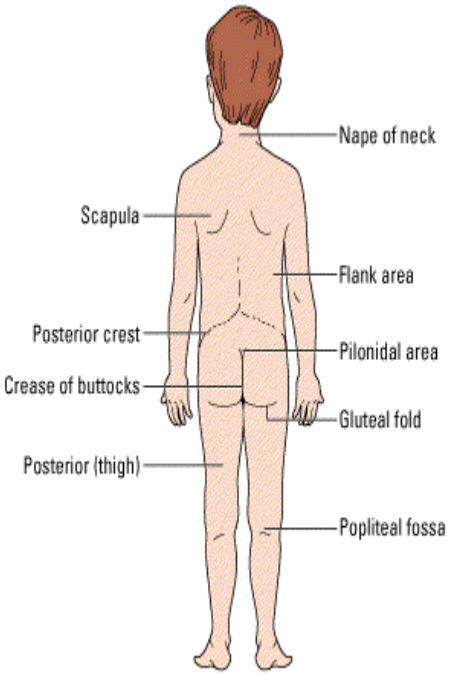
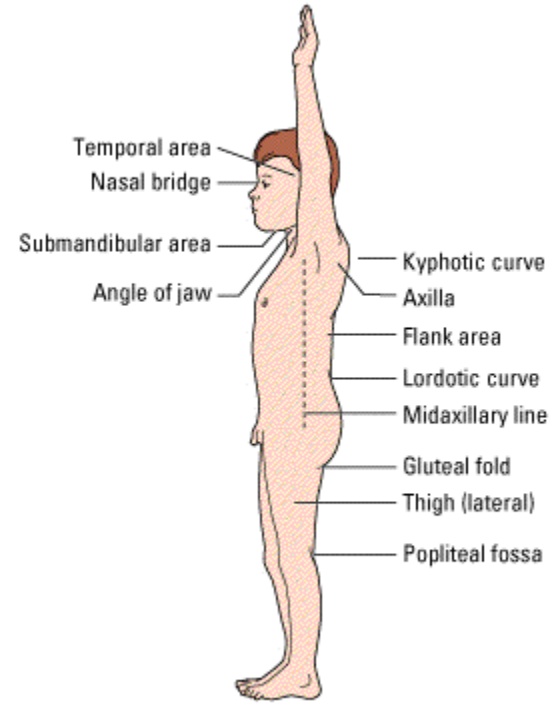
ANATOMICAL LANDMARKS



Body, Front View



Body, Back View



Body, Side View

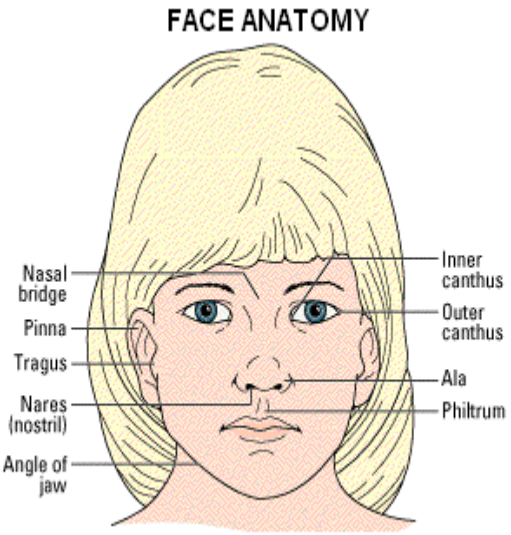


Illustration of landmarks of the face

IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAIL IN THE MANNER DESCRIBED ABOVE

COMPLAINT NO.	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE

Submission Date: **Patient's signature**

All information given is kept confidential