Homeopathic Case Proforma

C O N F I D E N T I A L

Name :

Date :

Address :

Telephone : Residence : Office : Mobile :

E-Mail :

Age : Sex : Male / Female D.O.B. :

Vegetarian / Non Veg. / Egg. Veg. Single/Married/Divorced/Widowed

Occupation (Nature of Work) :

Educational qualification:

Your Present family structure; with basic info. about each member and your relations and responsibilities. Your daily routine of 24 hours.

PLEASE READ THIS FIRST BEFORE COMPLETING THIS FORM

You have come here to get well. We are here to select the 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 make up.

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 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.

You can printout the form and fill in. Where more details need to be written, take a separate paper.

THIS QUESTIONNAIRE HAS 8 PARTS :

1. History of your present illness.

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

3. About health of your family.

4. About all the parts of your body.

5. Factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.

6. 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.

7. About your sleep and dreams.

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

HOW TO DESCRIBE YOUR 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", "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/place of problem, sensation, pain or eruption. 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.

HOW DID THE COMPLAIN START:

Describe the origin or beginning of the complaint.

HOW DID IT PROGRESS:

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 in later pages. 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 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, and in what way ?

ORIGIN OR CAUSE : Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, overexposure to cold, heat etc.)?

DESCRIBE MAIN COMPLAINTS AND OTHER ASSOCIATED TROUBLES : (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES).

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

PREVIOUS DISEASES & DRUG USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus our body is strengthened. Thus it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken. Mention **when and how long** you suffered & **how and when** it was cured/removed

In the list below, are names of various conditions to consider [and add if your problem is not included]:

Typhoid, Cholera, Food poisoning, Worms, Diarrhoea, Dysentery, Measles, German Measles, Chicken-pox, Small-pox, Mumps, Whooping cough, Malaria, Jaundice, Any Liver, Spleen, or Gall bladder disease

Miscarriage, Abortion, Currettings, Sickness during Pregnancy, etc.Prolapse of uterus,

Malnutrition, Rickets, Rheumatism, Backache,

Any venereal disease like Syphillis, Gonorrhoea etc.

Any heart trouble, Blood pressure, Giddiness

Nephritis (Kidney or urine trouble) Diabetes etc. Prostate trouble

Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles Uterus, Renal stones, Gall stones, Phimosis, Hydocele, Cataract etc. Mode of anaesthesia : general-local

Diptheria, Septic Tonsils, Adenoids

Recurrent infections-Sinusitis Bronchitis-Eosinophilia, Cold-Fever-Chill. Pneumonia, Asthma-Pleurisy- T.B.

Any serious shock, grief, disappointments, fright, mental upset, depression or nervous break down.

Chronic Headaches, Numbness, Cramps, Fits, Convulsions Polio, Paralysis etc. Meningitis -Any Lumbar puncture Any major accident or injury to body or head. Any occasion of unconsciousness. Any major bleeding from Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Herpes, Urticaria, Allergy. Ulcers on any part of body.

Following is a sample table about how to describe the above

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

Any extra remarks or information

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

FAMILY INFORMATION

Mention about the following relatives, as: Alive / Dead; Age; Diseases suffered; Cause of death.

Paternal Grand Father / Paternal Grand Mother / Maternal Grand Father / Maternal Grand Mother / Father / Mother / Paternal Uncle / Paternal Aunts / Maternal Uncle / Maternal Aunts / Cousin Brother &Sister on Father's Side / Cousin Brother &Sister on Mother's Side / Brothers / Sisters.

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.

Did any of your relatives have trouble similar to you?

How many brothers - sisters are you? (including those who died, if any)

PERSONAL HISTORY

*About your birth :

Did your mother have any problem during pregnancy?

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

Was there any difficulty about your birth? Give Details.

At what age did you start: Teething Sitting Standing Walking Speaking Urine control / bed-wetting etc.

Eating indigestible things like chalk, lime, earth, slate-pencil etc.

Any other problem about your growth & development?

Tick mark (√) if any animal bites such as Dog Rat Snake Scorpion

Vaccination & Inocculations : Indicate number of times you were vaccinated for the following :

Small-pox Polio Cholera Measles Triple B. C. G. Typhoid Tetanus

Was there any reaction or particular trouble after any of above vaccination or inocculations? Give details :

(If married) How is the health of your husband / wife. Number of children living and dead. If dead, state causes.

Mention ages of children and their condition of health: Child's Name ; Male/Female ; Age ; Disease Suffered

Any abortions, miscarriages or still births?

Your Habits - How much?

Smoking, Snuff, Chewing tobacco, Alcohol, Tea, Sleeping Pills, Laxatives / Purgatives, 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 time are you specially 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 (√√) , 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				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 colour 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 symtoms 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 ? Gonorrhoea ? 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, colour, 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, colour, 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 ? Do you pass any gas from vagina ?

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 gums. 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 ?

Is there any complaint of SKIN : such as itching, eruptions ulcers, warts, corns,

peeling etc.? (Describe its nature) Any change in colour of the skin or spots of any part of the body ?

Is there any complaint or abnormality of the NAILS or skins around ?

Is there any complaint with the HAIR such as falling, graying, dandruff, dryness, oily , poor excessive or unusual growth ?

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

Have you a tendency to bleed ?

Are your troubles one sided? which one ? Or more on one side ?

Do they proceed from one to the other side ? Or do they alternate or shift ?

Is there any trembling ? When ?

Is there any senses of weakness ? Where ?

When is it more or less ? Is it in any particular 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”. If in hot weather you feel uneasy, 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.

Factor	Effect produced	Factor	Effect produced
Hot weather		Cold weather	
Rainy weather		Cloudy weather	
Change of season		Thunder - storm	
Covering		Warm bath	
Sun		Cold bathing	
Walking		Running	
Climbing stairs		Going downstairs	
Riding in bus, car etc.		Lying	
Lying on back		Lying on left side	
Lying on right side		Lying on abdomen	
Lying with head low		Sitting	
Sitting erect		Standing	
Looking up		Looking down	
Looking from high places		Looking from moving object	
Noise		Sudden Noise	
Music		Light	
Strong smells		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	
Smoke		Touch	
Pressure		Massage	

Tight Clothes	Before Sleep
During Sleep	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
Draft air	Biting or 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	Over eating
Working in water	Fanning

What can you tolerate more – heat or cold?

MIND

It is now universally acknowledged that your mind has tremendous influence on your 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 make up.

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 ?

Are you sexual-minded ?

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 :

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

Your nature when you were young or in childhood.

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 ?

Circle types of dream that you have

Animals Robbers Travelling Houses Death, Whose? Cats - Dogs Thieves Riding Fruits Dead bodies

Horse Anxious Flying Trees Dead persons Wild animals Fearful Swimming Water Part of Body

Snakes Ghosts Drowning Snow Suicide Being Hungry Fire Accidents Talking Business

Being Thirsty Lightning Falling Singing Money Drinking Storm Shooting Dancing Day's work

Eating Rain Wars Pleasant Forgotten work Vomiting Romantic Pain Praying Failure / Exams

Passing stool Urinating Blood-bleeding Excrements / soiling Sexual Pleasure Rape

Nakedness Illness Sickness Mutilations Religious Temple Church God Unsuccesful 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 ? If any other, specify in the space below: Of people Children Parties Feasts Marriage Of events Remote Recents Future Prophetic Physical Exertion Mental Exertion Fatigue Coloured Multi-Coloured

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

1) Please tick mark once (√) if the child or you as child had any of the following qualities : Tick mark twice (√√) if they are more intense :

	Tick here		Tick here
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like :Hyperactivity	
Biting nails		Destructiveness	

Thumb-sucking	Possessiveness
Courage	Competition - winning spirit
Picking and playing with	Sensitive / Emotional
(a) mother's body parts	Slibling jealousy
(b) shawls, handkerchieves	Dullness of memory
(c) anything else	Unusual desires (for what)
Any special skills	Religious
Boasting	Slowness (in what)
Stealing	Laziness / Indolence
Telling lies	

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 any other aspects you feel are striking about the child [or of you when you were a child]

4) Describe one incident from the child's life when he/she very upset [or in you when you were a child]