

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

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| --- | --- | --- | --- |
| Date: | | Time: | |
| Name : | | | Surname: |
| Date of birth: | Age : | | Sex : Male / Female |
| Full Address : | | | |
| Nationality : | | Native place: | |
| Mobile: | | Telephone (R) (with code): | |
| E-mail id: | | | |
| Religion: | | | |
| Diet: Veg / Mixed / Egg | | | |
| Marital status: Single / Married / Divorce / Seperated / Widowed / 2nd marriage or any others | | | |
| Education: | | Occupation: | |
| Nature of work: | |
| Address of workplace: | | | |
| Telephone (work) | | Alternative email (if any) | |
| Languages 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?

Please mention your complaints/suffering in detail along with the duration since when have you been suffering.

**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 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.

In the following order please mention each complaint

Explain as follows for each complaint that you suffer in detail.

1. Location :

- Which is the affected part or area specify.

- If possible draw and show the exact location.

2. Sensation:

- Type of pain please explain. And please describe how you feel during your complaint and suffering.

3. Concomitants:

- Any complaints that you suffer but is not related to the main complaint but yet exist along with the main complaint (eg., feel like passing urine when you have headache, pain in nostril region when on empty stomach etc.,)

4. Modality:

- When, which part, what, how does your complaint increase / decrease?

- Any specific posture would you like to obtain during your complaint?

- Time specify when you feel better or worse.

- Thermal relationship like season/cold/hot/moderate that makes your complaint better or worse.

5. Associated complaints:

- Any complaint that you suffer alongside with the main complaint.

6. Radiation/Extension:

- Any pain radiating to else where? If yes, where? To which part?

- Any pattern like shifting of pain randomly here and there that can’t be mentioned but keeps shifting?

- Does your complaint begin with Left to right /Right to left/ Right to left and vice versa/ right to left and agin back to right/left to right and again back to left.

- Specify any other discomfort of the radiated pain caused.

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| --- | --- | --- | --- | --- |
| 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. Homoeopathic 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.

**DETAILS OF YOUR PAST ILLNESS:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Sr. no. | Diseases suffered from | Age (aprox.) | Duration | Medication taken | Fully recovered or not | Any other |
|  |  |  |  |  |  |  |

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

**FAMILY HISTORY :**

*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.

*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.** | FAMILY MEMBER | AGE | MALE/FEMALE | DISEASE SUFFERED |
|  |  |  |  |  |

**DEVELOPMENTAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| **MILESTONE** | **AT WHAT AGE DID THEY START** | **ANY PROBLEMS DURING** |
| **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** |
|  |  |  |  |  |  |

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 mention likes,dislikes,disagree any food and 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.**

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

Dreams: type of dreams- animals/birds/murders/horror/sexual/thriller/ what were you doing in the dream/any repetitive dreams? / do the dreams wake you from sleep? Are your dreams pleasant?

Fears: any particular fears of heights/ water/animals/ crowded places/ others

What is your experience during that fear? What do you feel like doing?

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, Gonorrhea, 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 | FACTORS | EFFECT |
| After sleep |  | Hot weather |  |
| After afternoon nap |  | Cold weather |  |
| Loss of sleep |  | Rainy weather |  |
| Before stools |  | Cloudy weather |  |
| During stools |  | Change of season |  |
| After stools |  | Thunderstorm |  |
| Coughing |  | Coverings |  |
| Sneezing |  | Warm bath |  |
| Laughing |  | Sun |  |
| Talking |  | Fanning |  |
| Reading |  | Air condition |  |
| Writing |  | Cold bathing |  |
| Stooping |  | Riding in a bus, car, etc |  |
| Before important engagement |  | Lying |  |
| Before exams |  | Lying with head low |  |
| When angry |  | Lying on back |  |
| When worried |  | Lying on left side |  |
| When sad |  | Lying on right side |  |
| After weeping |  | Lying on abdomen |  |
| Consolation / sympathy |  | Running |  |
| In a crowd |  | Walking |  |
| In a closed room |  | Climbing stairs |  |
| When thinking of illness |  | Going downstairs |  |
| Full moon |  | Sitting |  |
| New moon |  | Sitting erect |  |
| Morning  Afternoon |  | Standing  Looking up |  |
| Evening |  | Looking down |  |
| Night |  | Looking from high places |  |
| Bathing |  | Looking at moving objects |  |

|  |  |  |  |
| --- | --- | --- | --- |
| FACTORS | EFFECT | FACTORS | EFFECT |
| Noise |  | Biting / chewing |  |
| Sudden noise |  | Blowing nose |  |
| Music |  | When alone |  |
| Smell |  | In company |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Strong smells |  | Physical exertion |  |
| Light |  | Belching |  |
| Dust |  | Passing gas |  |
| Smoke |  | After haircut |  |
| Touch |  | Combing hair |  |
| Pressure |  | Brushing teeth |  |
| Tight / loose clothes |  | Moonlight |  |
| High places |  | Opening the mouth |  |
| Narrow places |  | Smoking |  |
| Open air |  | Hanging the limbs |  |
| Draft of air |  | Raising the arms |  |
| When constipated |  | Near sea |  |
| Before urine |  | Shaving |  |
| During urine |  | Stretching |  |
| After urine |  | Swallowing |  |
| Before menses |  | Listening to others talk |  |
| After menses |  | Vomiting |  |
| After sweating |  | Yawning |  |
| When fasting |  | Moving the eyes |  |
| After eating |  | Opening the eyes |  |
| Drinking |  | Closing the eyes |  |
| After sexual intercourse |  | Getting feet wet |  |
| Massage |  | Overeating |  |
| Before sleep |  | Working in water |  |
| During sleep |  | 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. 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?

11. Are you sexual-minded?

12.Any Unwanted Thoughts At Anytime?What Are They?

13.Have You Any Imaginary Sensations Or Fears?

14.How Is Your Memory?For What It Is Poor ? Eg: Names,Places,Faces Etc.,

15.Are You Esily Irritated?

16.What Makes You Angry ? Do You Get Violent?

17.What Bodily Symptoms Do You Develop During Angry? Eg: Trembling,Sweating Etc.,

18.Do You Like Company ? Or Like You To Remain Alone?

19.How Seriously Are You Affected By Disotrder And Uncleanliness In Your Sourroundings?

20.What Are The Greatest Grieves That You Gone Through Your Life?

21.What Are The Greatest Joys That You Had Have In Your Life?

22.What Activities You Deeply Like?

23.Are There Any Matters Which You Deeply Dislike?

24.In Your Opinion,Whar Aspect Of Your Minds And Moods Are Not Agreeable To You,That Inspite Of Your Awareness And Maturity,You Are Unable To Change?

25.Give A Clear Cut Of 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 Condtions? If So Describe In Detail.

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?

**NOTE : Enclose if any old/present scan reports.**