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CASE RECORD FORM

Name:		Date:	
Address:		Age:	
Occupation:		Mobile:	

Please read this first before filling the form

Homoeopathic medicine is mainly selected on the symptoms what tell your doctor and filling yourself and your individuality which makes you unique (separate from others). Each one of these questions has a definite meaning and significance for us. To collect your symptoms your doctor ask you such a question which you may think irrelevant but the correct answer of that question help to select correct medicine. All of your information will be secret to us.

CHIEF COMPLAINTS

Tell your main problem in details as much as you can

➢ What are your complaints?	
➢ Since when are you having the complaints?	
➢ Location: Please give the exact location of pain. Is there any extension of pain?	
➢ Sensation: Express in your own words 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?	
➢ What are the factors that influence your trouble? E.g. weather, food, pressure, posture, anxiety or any others?	
When and how do you feel better or worse?	
➢ Mental state: Is there any changes like anxiety, anxious, worriedness, restlessness, fear, delusion or despair during this problem?	

➢ Do you feel any other complaints before, during or after in relation to your chief complaint?	

PREVIOUS DISEASES & DRUGS

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 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 treatments you have taken.

➢ What do you know about your developmental history (Gestational age, during delivery, teething, speaking, walking, eating)?	
➢ Describe your nature as a child?	
➢ Did you get any injury, sprain, head injury or burn?	
➢ Did you suffer from any itching, scabies, eczema, ringworm, psoriasis or even warts?	
➢ Did you poisonated by anything or bite history by insects, spider, scorpion, honeybee, rats, cats, dogs, snakes or others?	
➢ Did you suffer from headache, migraine, sinusitis or others?	
➢ Did you suffer from any tumour, ulcer, cancer, TB, Gonorrhoea, Syphilis, HIV, IBS, hypertension, diabetes, arthritis, thalassaemia, Insanity, epilepsy, disability,	
➢ Did you suffer from allergy, asthma, cold, cough, tonsillitis, mumps, otorrhoea,?	
➢ Did you suffer from typhoid, malaria, pneumonia, dengue, chikungunya, rheumatic fever or any other fever?	
➢ Did you suffer from diarrhea, constipation jaundice, indigestion hemorrhage from your body?	
➢ Did you suffer from any toothache, teeth	

decay or teeth extraction?	
➢ Did you feel any burning sensation in your palm or sole?	
➢ Did you have any operation, S/S, MR, D&C or others?	

FAMILY HISTORY

Did they (father, mother, paternal grandpa & grandma, maternal grandpa, & grandma, paternal & maternal uncle, brother-sister, son –daughter, husband-wife) had or have	
Tumour, Ulcer, Cancer, TB, Allergy, Asthma, Eczema, Psoriasis, Gonorrhoea, Syphilis, HIV, IBS, Hypertension, Diabetes, Arthritis, Thalassaemia, Insanity, Disability, Epilepsy, Warts…	

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is necessary for us to understand your emotional and intellectual nature in addition to the physical characteristics. We can thus treat you as a whole. Please answer the following questions frankly without any hesitation.

How is your anger?	
Are you easily irritated?	
What triggers your anger?	
How do you feel after anger or excited?	
or if someone offers sympathy and consolation?	
Do you get anxious? What circumstances make you anxious?	
What are the greatest joys that you have had in life?	
What are the greatest grief that you have gone through in your life? What effects did they have on you?	
When are you most cheerful? When are you most depressed?	
What activities you deeply enjoy,… hobbies?	
Are there any matters which you deeply dislike?	
Do you cry or become emotional easily? What makes you cry?	
Do you have any fear or any phobia or panic 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? Have you any?	
What about your ego/ proud/ personality? What makes you hurted easily?	
Do you have any depression?	
Do you ever become suicidal? When?	
Which matter do you think frequently?	
Any unwanted thoughts any time? What are they?	
Do you experience any strange and unexplainable sensations or facts or hearing voices?	

How is your memory?	
For what is it poor? e.g. names, places, faces, what you have read, etc.	
Do you prefer to be alone or with company in your leisure time?	
Give a clear-cut picture of your situation in life and your relationship with each of your family members?	
How do you want to complete your daily work? Slowly, hurriedly, perfectly, Neat & clean, impatiently, uncleanly?	
Are you doubtful, suspicious, proudful, revengeful, worried, jealousy, unhappy, despair of anyone or anything?	
How does the future look to you?	

PERSONAL HISTORY

Life Style:

Personal Habits	
Socio- economical condition	
Any addiction? Smoking, Drugs, Alcohol or others?	

FOOD & DRINKS:

How is your appetite?	
How is your dietary habit?	
When are you hungry? What happens if you have to remain hungry for long?	
How much thirst do you have?	

Please Put plus (+/++) or minus (-/--) mark if you like/dislike the following foods

Sour,		spicy	
chilly,		ice-cream	
bitter		cold food	
sweet		cold drinks	

salt		hot food	
pickles		hot drinks	
fish		fast food/junk food	
meat		allergic food	
milk		or others	
egg		Which food disagrees or aggravates your complaints? ----------	
oily			
fatty			
fried			

STOOL

Do you have any problem about bowel movements?

☐constipation/ ☐loose motion/ ☐diarrhoea/☐dysentery/☐IBS/
☐unsatisfactory/ ☐ ineffectual/ ☐frequent urging/ ☐no urging

URINATION & URINE

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

Any difficulty about the flow? ☐burning, ☐hasten, ☐slow to start, ☐interrupted, ☐slow & feeble, ☐dribbling, ☐forked, ☐ jerking, ☐involuntary urination or etc.?

SWEAT/PERSPIRATION

How much do you sweat?	
Where and on what part do you sweat most? palms or soles?	
What is the smell like? E.g. offensive, foul, pungent, sour, or urinous	

SLEEP & DREAM

Describe your posture in sleep. (E.g. on back, abdomen, sides)

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

Do you have dreamt any dreams frequently? Such as:

☐ Animal, ☐ Snakes, ☐ Robbers, ☐ Ghosts, ☐ Flying, ☐ Dead body, ☐ Dead ☐ person, ☐ Sexual pleasure, ☐ Failure /exams, ☐ Police, ☐ Danger, etc.

SEXUAL SPHERE

Have you any dislike or aversion for sexual intercourse?	
Any particular feeling or symptoms that appear before, during or after sexual intercourse?	
Any history of masturbation or excessive sexual indulgence in past and present? What is its effect?	

For men: Do you suffer from any sexual weakness, erectile dysfunction, premature ejaculation, nightfall or seminal emissions? Describe.

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

Menstrual history: At what age did your menses start? Did you have any trouble?

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

Menstrual cycle:	
Duration (days):	
Quantity of flow (e.g. profuse, scanty, moderate):	

Color of flow:	
Smell if any from the flow:	
Staining, are the stains difficult to wash?	
Pain:	
If menopausal, mention the age of menopause. Any complaints around that time?	
Is there any white discharge? If so, mention the nature, color, consistency and smell of discharge. Any itching, burning, etc. due to discharge?	
Any trouble with breasts?	

Obstetrics history: Number of times you have conceived

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

Delivery:

Any complaints during delivery?	
Were they normal deliveries/seazarian section?	
Reason?	

Lactating history: Any complaints during that period?

FACTORS THAT AFFECT YOU

Below is a 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?

Factors	Effect	Factors	Effect
Change of weather/ season		Riding in bus, car etc.	

Cold weather		Tight clothes	
Rainy weather		Fanning	
Hot weather		Sudden noise	
Thunder –storm		Before exams	
Covering		Sun	
Clothing		Temperament	

PHYSICAL EXAMINATION

1. Physical make-up/ constitution:
2. Tongue:
3. Nail:
4. Anaemia: Jaundice: Nutrition: Energy:
5. Wt: B.P.: Puls:

PATHOLOGICAL EXAMINATION

1. A reference note from your referring doctor.
2. All your recent & old medical reports (e.g. C.B.C., ESR, U.S.G, X-ray, ECHO, etc)

DIAGONOSIS:

LOGIC OF PRESCRIPTION:

ADVICE:

TREATMENT:

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