



Shubham Homeopathy

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CASE - RECORD

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here to get well. We are here to select the best possible medicine for you. In order to do that, we depend on your co-operation. HOMEOPATHIC 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 out all about you, we shall be asking you many questions. Each one of those question 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 homeopathic 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 FORM HAS 8 PARTS:

1. About your past illnesses and family 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 you 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.

CONFIDENTIAL

Date: _____

Name : _____

(Begin with Surname)

Address : _____

Telephone: Residence: _____ Office: _____

Age : _____ Sex: Male / Female: _____

Vegetarian / Non-Veg. / Egg.-Veg.: _____ Single / Married / Divorced / Widowed _____

Occupation (Nature of Work) : _____ Education : _____

Referred to us by: _____

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

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, exposure to cold, heat etc.)?

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 when 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 tick 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			
<u>Bread</u>				<u>Cabbages</u>			
<u>Butter</u>				<u>Onions</u>			
<u>Fats</u>				<u>Warm food / drink</u>			
<u>Milk</u>				<u>Cold food / drink</u>			
<u>Coffee</u>				<u>Fruits</u>			
Mud / Chalk				Anything else			

STOOL

Do you have any problem regarding your stools?

When and how many times a day do 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 - HEART - 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 and after sexual intercourse?

Do you suffer from any sexual disturbance?
(Homosexual inclination etc.?)

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

Did you suffer from any Venereal disease?
Syphilis ? Gonorrhoea?

Do you have increased desire or decreased
desire for sex?

What is the method you use for family planning?

FOR MEN

Any difficulty in erection?
Wanted erection? Unwanted erection?

Weak 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?

In what age did it 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 details:

If you have any 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 on any part of the body?

Is there any complaint or abnormality of
the NAILS or skin 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 sense of weakness? Where?

When is it more or less?

Is it in any particular part of the body?

FACTORS THAT AFFECT YOU

Below are 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. 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, 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 complain 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
<u>Hot weather</u>		<u>Walking</u>	
<u>Cold weather</u>		<u>Running</u>	
<u>Rainy weather</u>		<u>Climbing stairs</u>	
<u>Cloudy weather</u>		<u>Going downstairs</u>	
<u>Change of season</u>		<u>Riding in bus, car etc.</u>	
<u>Thunder - Storm</u>		<u>Lying</u>	
<u>Covering</u>		<u>Lying on back</u>	
Warm bath		Lying on left side	
Sun		Lying on right side	
<u>Cold bathing</u>		<u>Lying on abdomen</u>	

	Effect		Effect
Lying with head low		Drinking	
Sitting		After sexual intercourse	
Sitting erect		Dust	
Standing		Smoke	
Looking up		Touch	
Looking down		Pressure	
Looking from high places		Massage	
Looking at moving object		Tight Clothes	
Noise		Before Sleep	
Sudden Noise		During Sleep	
Music		After Sleep	
Light		After afternoon nap	
<u>Strong smells</u>		<u>Loss of sleep</u>	
<u>When constipated</u>		<u>Before stools</u>	
<u>Before Urine</u>		<u>During stools</u>	
<u>During Urine</u>		<u>After stools</u>	
<u>After Urine</u>		<u>Coughing</u>	
<u>Before Menses</u>		<u>Sneezing</u>	
<u>During Menses</u>		<u>Laughing</u>	
After Menses		Talking	
After Sweating		Reading	
When Fasting		Writing	
After eating		Stooping	

	Effect		Effect
Before important engagement			Passing gas
Before exams			After hair cut
When angry			Combing hair
When worried			Brushing teeth
When sad			Moonlight
After Weeping			Opening the mouth
Consolation / Sympathy			Smoking
In a crowd			Hanging the limb
In a closed room			Raising the arms
When thinking of illness			Near Sea
Full moon / New moon			Shaving
<u>Morning</u>			<u>Stretching</u>
<u>Afternoon</u>			<u>Swallowing</u>
<u>Evening</u>			<u>Listening to others talk</u>
<u>Night</u>			<u>Vomiting</u>
<u>Bathing</u>			<u>Yawning</u>
<u>Draft air</u>			<u>Moving the eyes</u>
<u>Biting or chewing</u>			<u>Opening the eyes</u>
<u>Blowing Nose</u>			<u>Closing the eyes</u>
When alone			Getting feet wet
In company			Over eating
Physical exertion			Working in water
Belching			Fanning

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 to 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 jealous?

In which matters 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?

Depressed, 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. In spite 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 thought 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?

SLEEP

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?

Please draw something that comes to your mind at present or your favorite drawing :-

Circle types of dream that you have

Animals Cats-Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Traveling Riding Flying Swimming Drawing	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?	If any other, specify in the space below:	
Of people Children Parties Feasts <u>Marriage</u>	Of events Remote Recent Future <u>Prophetic</u>	Physical Exertion Mental Exertion Fatigue Colored <u>Multi - Colored</u>		

FOR CHILDREN or YOU AS A CHILD
(IN CASE OF ADULTS)

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 ears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like:	
Hyperactivity		Biting nails	
Destructiveness		Thumb-sucking	
Courage		Picking and playing with	
Possessiveness		a) mother's body parts	
<u>Competition-winning spirit</u>		b) <u>shawls, handkerchiefs</u>	
<u>Sibling jealousy</u>		c) <u>anything else</u>	
<u>Any special skills</u>		<u>Religious</u>	
<u>Unusual desires (for what)</u>		<u>Dullness of memory</u>	
<u>Boasting</u>		<u>Slowness (in what)</u>	
<u>stealing</u>		<u>Laziness / Indolence</u>	
<u>Telling lies</u>		<u>Sensitive / Emotional</u>	

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

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 'a 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 26 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.

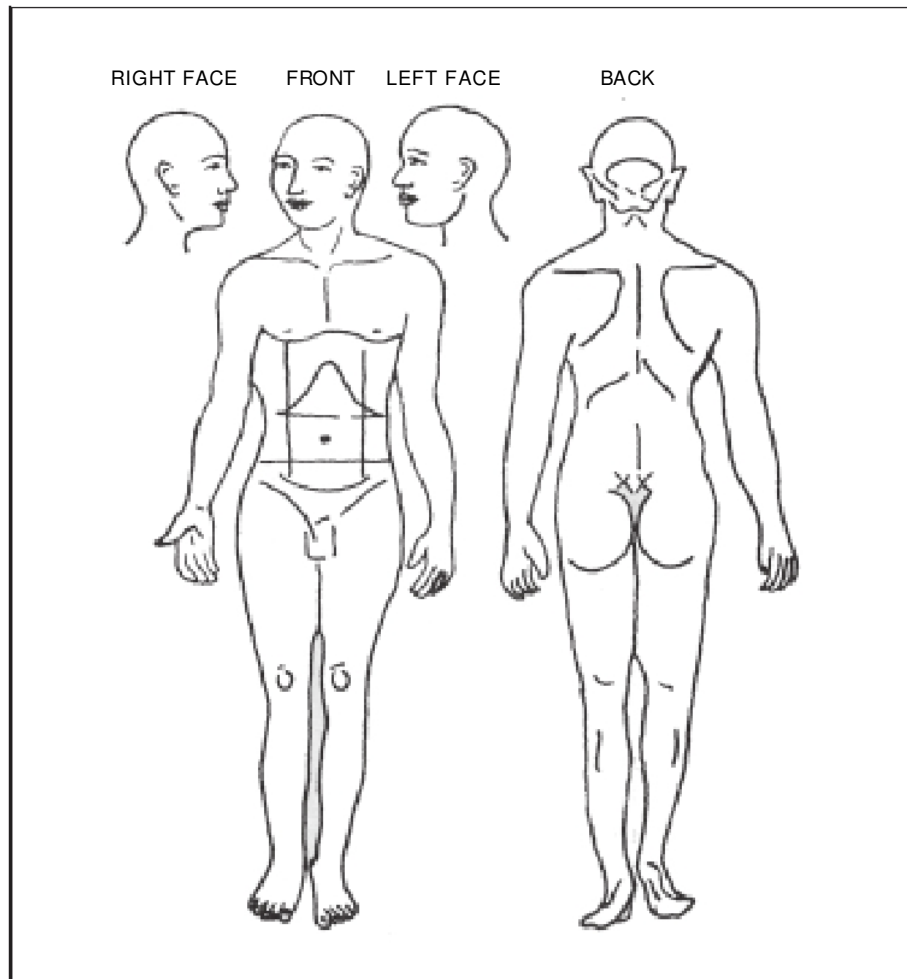
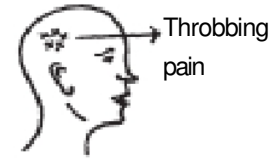
WHAT MAKES YOU WORSE OR BETTER : Many factors are likely to influence your trouble. Some

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 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?

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 your head please mark as shown u



IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAILS
IN THE MANNER DESCRIBED ON PAGE 24

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

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