**Case record form**

**Homeopathy healing**

*The purpose of this case form is to get complete information, some of which might be missed while taking a case history. When filled carefully and honestly, this form will to help me get information to treat you better. If you prefer to just speak rather than fill the form, please read it carefully and note down points you would like to discuss or mention.*

**Date:**

**Name:**

**Age:**

**Gender:**

**Occupation:**

**Email:**

**Tel:**

**Skype id:**

**Address:**

**Reference**

**Height and Weight -**

**Chief complaint --- Describe the complaint in detail…what exactly happens, when, how often, how long it lasts. How did it begin, what might have been the reason (as per your understanding). Has the complaint changed – e.g., become more or less severe, or new sensations, increased frequency etc. What might be the reason for this?**

**ORIGIN OF 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.)?

**Effect of the problem on you**

**PAST HISTORY OF ILLNESS (Mention the name of disease you suffered in past)**

**-**

**-**

**-**

**-**

**-**

**FAMILY HISTORY OF ILLNESS**

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**FACTORS THAT AFFECT YO****U**

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.

|  |  |
| --- | --- |
|  | Effect |
| Hot weather |  |
| Cold weather |  |
| Rainy weather |  |
| Cloudy weather |  |
| Change of season |  |
| Thunder - storm |  |
| Covering |  |
| Warm bath |  |
| Sun |  |
| Cold bathing |  |

|  |  |
| --- | --- |
|  | Effect |
| 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 |  |

|  |  |
| --- | --- |
|  | Effect |
| 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 |  |

|  |  |
| --- | --- |
|  | Effect |
| 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 otherstalk |  |
| Vomiting |  |
| Yawning |  |
| Moving the eyes |  |
| Opening the eyes |  |
| Closing the eyes |  |
| Getting feet wet |  |
| Over eating |  |
| Working in water |  |
| Fanning |  |

|  |  |
| --- | --- |
|  | Effect |
| Before importantengagement |  |
| Before exams |  |
| When angry |  |
| When worried |  |
| When sad |  |
| After Weeping |  |
| Consolation /Sympathy |  |
| In a crowd |  |
| In a closed room |  |
| When thinking ofillness |  |
| Full Moon / NewMoon |  |
| Morning |  |
| Afternoon |  |
| Evening |  |
| Night |  |
| Bathing |  |
| Draft air |  |
| Biting or chewing |  |
| Blowing Nose |  |
| When alone |  |
| In company |  |
| Physical exertion |  |
| Belching |  |

**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 |
| Bitter |  |  |  |
| Salt extra |  |  |  |
| Sweet |  |  |  |
| Sour |  |  |  |
| Bread |  |  |  |
| Butter |  |  |  |
| Fats |  |  |  |
| Milk |  |  |  |
| Coffee |  |  |  |
| Mud / Chalk |   |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  Like | Dislike | Disagrees |
| Eggs |  |  |  |
| Spicy food |   |  |  |
| Meat |  |  |  |
| Fish |  |  |  |
| Cabbage |  |  |  |
| Onions |  |  |  |
| Warm food / drink |  |  |  |
| Cold food / drink |  |  |  |
| Fruits |  |  |  |
| Anything else |  |  |  |

**Describe your nature and personality in brief. Take help of a family member or friend if needed. Useful information would be – how your nature is different from your friends or family members. Examples…short-tempered, calm, jealousy, revengeful, sensitive, anxious, inferior, egotistic, impulsive, indecisive, quarrelsome, fearful, bold, hurried, slow, quiet, talkative, closed, suspicious, feeling cheated or unlucky, sadness, competitive, weeping easily etc.**

**What things can upset, worry or disturb you very much. Do you get anxious or angry in any situations?**

**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 introverted or extroverted? Please explain.**

**Have you had any period of stress in your life? Was there any time when you found it difficult to cope or had to make a great effort to overcome the circumstances. Have you had any disappointments. Think of any memories even from childhood, which have left a deep impression, or affected you much. Do these still affect you?**

**Do you have any problems or stress in your relationships – with your parents, siblings, spouse or children?**

**What do you do to handle stress? What really works for you?**

**Sensitivity? situation? people? words?**

**Do you have any “fixed” habits – things that you do very often, or repeatedly, especially to an uncommon degree? E.g., cleanliness, perfectionism, alcohol, exercising for 3-4 hours a day, praying for 2 hours, checking the same thing again and again etc. Please give some classic examples.**

**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 you 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 clearcut picture of your situation in life and your relationship with each of your family members, friends and associates in work.**

**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?**

**DREAMS**

**What are the dreams you get?**

**Any repeated patterns, Any dreams from childhood?**

**CHILDHOOD**

**Nature? Habits? fears? dreams? relationships with everyone else? sensitivities?**

**Are there any peculiar symptoms you have noticed? E.g., sweating while eating; complaints come only at night; much affected by some weather, same dream recurs again and again, sensation of a hair on tongue, feeling someone is behind you etc, *anything* about yourself that you have experienced definitely *or* often.**

**Homoeopathic medicines taken before ? if yes, mention the name.**

**Mention the name and doses of medicines which you are taking in allopathy if any.**

**Please write the findings of any investigations done recently. And send the pictures of the same to the undersigned mail.**

***Pl share filled up case record form on below email id –*** ***gauranghg@gmail.com***