



Homeopathic Case - Intake

In order to find out all about you, we shall be asking you various questions. Each one of these questions has a definite meaning and significance. Even something that you think is not connected with your current health concern may be the most important factor in determining the correct homeopathic medicine. Please read each question carefully, think and if necessary, consult someone close to you and then answer completely. *Remember, whatever you tell us will remain absolutely confidential.*

CONFIDENTIAL

Date :

Name:

Address :

Telephone : Residence :

Office :

Age :

Sex: Male / Female

Occupation (Nature of work):



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PREVIOUS DISEASES & MEDICATION USED

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

FAMILY MEDICAL HISTORY INFORMATION

Relationship	Age	Health Concerns
Paternal Grand Father		
Paternal Grand Mother		
Maternal Grand Father		
Maternal Grand Mother		
Father		
Mother		

SR.NO	Brother /Sister	Age	Health Concerns
1.			
2.			
3.			
4.			

PERSONAL HEALTH HISTORY

Did your mother have any problem during pregnancy?



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Did she take drugs during pregnancy? What were they?

Was there any difficulty about your birth? Give details.

***Vaccinations:**

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 vaccinations of inoculations ? Give details:

Mention ages of children and their condition of health. Any abortions, miscarriage, or stillbirth?

Child's name	Male/Female	Age	Diseases Suffered

Your Habits	How much
Smoking	
Alcohol	
Caffeine	
Sleeping Pills	
Any other	



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ORIGIN OF CAUSE : Can you trace the origin 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?

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 (X) if you Like / Dislike the food or if the food disagrees. Put two tick mark s 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				Cabbages			
Butter				Onions			
Fats				Warm food/drink			
Milk				Cold food/drink			
Coffee				Fruits			
Mud/chalk				Other			



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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 to strain for stool? Even if soft?

Do you have belching or passing gas? Describe its character.

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

When do you get fever or chill ?

Do you experience any sense of heat or cold in

Any part of your body at any particular time?

CHEST-HEART – COLD – COUGH



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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 ? When?

SEXUAL SPHERE (GENERAL)

Any excessive indulgence in sex in past and present?

Any particular feeling or symptoms appear before , during and after sexual intercourse?

(Homosexual inclination etc.?)

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?

Any other trouble in sex? Describe in details

FOR WOMEN

Menses : How are the periods; regular or irregular?



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At what age did it start?

Was there any trouble then?

Mention number of days of flow.

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

Have you noticed any variation in quality and quantity of flow during menses?

Do you suffer in any way before, during or after menses ?If so, describe:

What symptoms did you suffer during menopause?

Do you feel the 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 :



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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 :

Do you have 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 complaint of skin: such as itching, eruptions , ulcers , warts, corns, peeling etc.? (Describe its name)

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, gray, 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?

Do they proceed from one to the other side ?

Is there any trembling ? When?

Is there any sense of weakness ? Where? When is it more or less?



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FACTORS THAT AFFECT YOU

This section is most important. Do not go through it hurriedly . Think carefully about the effect of each factor before you write.

	Effect		Effect
Hot weather		Walking	
Cold weather		Running	
Rainy weather		Climbing stairs	
Cloudy weather		Going downstairs	
Change of season		Riding in bus, car etc.	
Thunder –storm		Lying	
Covering		Lying on back	
Warm bath		Lying on left side	
Sun		Lying on right side	
Cold bathing		Lying on abdomen	
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	



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Light		After afternoon nap	
Strong smells		Loss of sleep	
When constipated		Before stools	
Before urine		During stools	
During urine		After stools	
After urine		Coughing	
Before menses		Sneezing	
During menses		Laughing	
After menses		Talking	
After Sweating		Reading	
When Fasting		Writing	
After eating		Stooping	
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 limbs	
In a closed room		Hanging the arms	
When thinking of illness		Near sea	
Full noon /new moon		Shaving	
Morning		Stretching	
Afternoon		Swallowing	



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Evening			Listening to others talk	
Night			Vomiting	
Bathing			Yawning	
Draft air			Moving the eyes	
Biting or chewing			Opening the eyes	
Blowing nose			Closing the eyes	
When alone			Getting feet wet	
In company			Over eating	
Physical exertion			Working in water	
Belching			Fanning	

MIND

Are you anxious ? About which matters?

Are you fearful of anything such as Animals people being alone, darkness, death, diseases, 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?

In which matters are you impatient? Hurried?

How long do you remember hurts caused to you by others?

How much revengeful are you?



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What are you proud of? Does your pride get easily hurt?

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?

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.



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Do you like company? or like to remain alone?

How seriously are you affected by disorder in your surrounding ?

What is the greatest grief 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?

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?

Are you worried or unhappy over any and personal, domestic, economical , social or any other condition? If so describe in detail:

SLEEP

Describe your posture in sleep. On the back , side, abdomen etc.

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)



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

Please tick mark once (X) if the child or you as child had any of the following qualities: Tick mark twice (XX) 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	
Courage		Picking and playing with	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness /Indolence	
Telling lies		Sensitive/Emotional	

HOW TO DESCRIBE YOUR COMPLAINTS

LOCATION : Please give the exact location of 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.



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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 .

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

