**It is important that you read the following before filling out the patient history Form:**

I will try my level best to bring you back to optimal health with proper care using Homeopathic theology and practices. In Homoeopathy, to get the best remedy, it is necessary that the practitioner have your full co-operation and support. Homoeopathic remedy selection depends upon the "Totality of Symptoms" so I will ask many questions to you during this time period that may seem quite personal or "strange" but I will need answers to each question to the best of your ability to be able to find the best remedy for your particular and individualized case. Because the Homoeopathic system of medication depends upon this "Individualization" of the patient, all your answers will matter to me, no matter how irrelevant or small you may think it is. I will need for you to be as clear and detailed on your "Reactions to environment, Family history, Personal history, Past history, Expectations, Likes, Dislikes, etc." that are relevant to the questions posed or to your illness and case. So it is very important that you should understand each thing that belongs to you as an individual and not treat anything lightly or think of yourself as having a common ailment that others may also be going through. You are an individual with individual needs and my aim is to find that uniqueness in your case.

Your full co-operation and help will enable me to select your best possible single remedy.

With that said, it will be very important that you should be frank with me, and freely answer my questions, and don't think that any of what I ask is useless questioning or that it is not relevant to your symptoms or illness. In Homeopathy, the least likely symptom or ailment or condition, can be the one thing that leads towards the best remedy. Please read everything in this Form and try your level best to answer the questions as honestly and detailed as possible and even ask your family or friends to help you for the broader questions dealing with external events and social interactions. Please allow yourself adequate time to answer as best as you can and as fully as you can.

The most important thing to keep in mind as you work to answer the questions is that whatever you are telling me or writing in this Form will remain confidential and private between you and me.

**PARTS OF QUESTIONNAIRE AND APPOINTMENT:**

This questionnaire and appointment will require the following information from you:

- History regarding your chief and secondary complaints.
- History regarding your present and past illness(es).
- History regarding your past history (from birth to now) and family history.
- History about your marital status and circumstances.
- Environmental factors relevant to your illness/complaint.
- Mental/Emotional symptoms: this is very important regarding your history, so please be as specific as you can wherever possible. On many occasions in homoeopathy, remedy selection depend very much upon "Psychology" and your emotional state of the patient.
- Dreams, past and present, themes, feelings afterwards
- Sleep, Fears, Compulsions: Please try to think of these factors when writing your descriptions.
- Childhood, birth-traumas/circumstances.

If you require more space to answer some of the questions, feel free to write on a separate sheet and indicate the number of the question and any pertinent section headings.

**Please take your time and know that there is no right or wrong answer. Let us begin…**

# CONFIDENTIAL & PERSONAL CASE HISTORY QUESTIONNAIRE

**Today's Date:**

| | | | |
|---|---|---|---|
| **Name:** | | **Sex:** | |
| **Date of Birth and Birth Location:** | | **Education:** | |
| **Home Address and Type of Residence:** | | **Current Occupation:** | |
| | | **How long in occupation / Describe what you do:** | |
| **Best number to reach you:** | | **Work Place Contact#:** | |
| **Email:** | | | |
| **Emergency Contact (Relation):** | | **Address of current job:** | |

## MAIN COMPLAINTS:

**Please use this section to describe, in detail, the CHIEF complaint(s) and any and all associated events, circumstances, and any related complaints to your CHIEF complaint. For each complaint, as best as you can, list the onset of the complaint, the course that the complaint has taken (physical signs, emotional signs, etc), describe the pain and where it is situated and what makes it worse or better.**

**Please know that all details you noticed prior to and up to your complaint/illness is important – nothing is trivial.**

## Past Medical History:

List all childhood/adult illnesses:

List any vaccinations taken throughout life and when (Cholera/ Small Pox/ Polio/ Measles/ BCG/ Typhoid/ Tetanus/ others):

List any surgeries, any complications, etc:

## Family History

List any Family Medical Illnesses/Complications/Allergies (Make note if deceased, when and circumstances)

## Medications and Allergies

Medications currently taking:

Vitamins or nutritional supplements currently taking:

Allergies to medications:

Allergies to foods:

Allergies to milk or dairy:

## Food and Thirst

List food and drink cravings:

List food and drink aversions:

Do you crave sweet, salty, fatty, sour, spicy the most? (List them in order from the most like to the least liked):

Are you generally thirsty?
How much do you drink in a day?

What temperature do you prefer your drinks?

Do you drink coffee and if so how much in a day?

Do you drink alcohol and if so how much?

## Stomach

Any bloating, gas or other stomach problems/sensations:

Describe what you stomach feels like on a good day:

Describe what your stomach feels like on a bad day:

Do you tend to have constipation or diarrhea?

When does your diarrhea get worse or better?

How often do you have bowel movements?

Describe your stool (smell, color, consistency, sediments, quantity, etc):

Describe your urine (smell, color, consistency, sediments, quantity, etc):

Describe your perspiration (smell, color, consistency, sediments, quantity, etc):

## Sleep

Hour you go to bed:
How long does it take to fall asleep?
Are you refreshed in the morning?
Describe position you sleep in:

Do you tend to wake up at a particular time each night and why?

Do you do anything in your sleep (speak, laugh, shriek, toss about, grind your teeth, snore etc.)?

Do you remember your dreams and is there a theme to them?

Describe 1-3 dreams you had recently; List recent ones first:

Do you have or ever had recurring dreams, explain:

What do you fear?

## Generalities

What time of day tends to be the best for you:

What time of day tends to be the worst for you:

Do you tend to be chillier or warmer than others?

Do you prefer to be in a warm room or cold room?

Are you sensitive to noises and how?

Are you sensitive to smells and how?

Are you sensitive to touch and how?

Are you religious? Describe:

## Menstruation

What age did menses begin?
Describe your circumstances and emotions when they began:

Regular?
How many days apart?
Describe your flow (Color of blood/ Smell/ Texture/ Clots):

Flow amount/quantity:

Irregular?
Describe what irregular means to you:

Describe your flow (Color of blood/ Smell/ Texture/ Clots):

How do you (or did you) feel before, during and after menses (PMS)?

Describe any discharges other than your periods (Color, smell, abundance, texture and the time you get them the most):

Last Pap Smear and results:

## Pregnancy

Number of pregnancies:
Number of births and how old are they now:

Describe how you felt during your birth(s), before, during and after

**If no pregnancy** (live birth), what would you do or feel if you knew you might have a baby?

## Miscarriage

Number of miscarriages:
Describe how you felt before, during and after:

**If no miscarriage**, what would you do or feel if you knew you might have one?

## Abortions

Number of abortions:
Describe how you felt before, during and after:

**If no abortion**, what would you do or feel if you knew you might have one?

## Menopause

What age did menopause begin if applicable?

## Other Gynecological Illnesses

Have you had any chronic urinary infections or problems?

Have you had syphilis, gonorrhea, genital warts, herpes or any other sexual transmitted disease?

## Sexuality

Is your sexual desire above or below normal?

How do you feel about sex in general?

Do you consider yourself a sexual person?

How important is sex in a/your relationship?

Describe a romantic moment in the past:

Describe a romantic moment you think of:

**Sensitivity**

How sensitive on a scale of 1-100 are you to alcohol, drugs, medications, anesthesia, caffeine, foods, people talking, people's actions/reactions, animals barking or making noise, "things", etc?

(1 is not sensitive at all and 100 is so sensitive that you react to almost anything; 50 is you can go either way) List all things that you wish to list and describe what would make you more sensitive to that thing or less sensitive to that thing.

What would you do with $5000.00 if you were given it today?

This part of the case history is to take note any and all diseases from your past because, sometimes, current problems may be related to a previously untreated or mistreated ailment. No doubt it is a fact that any disease, poisoning, drug, or any accident leaves its mark and remains in your system as a weak point and may still be a weak point in your system. In homoeopathic treatment it is necessary to know about all the previous ailments that have taken away from your vitality and strength. So, it is important that you tell me about your previous ailments that you have suffered from in the past and the other treatments that you have taken. Remember, nothing is trivial.

Below, encircle those disease(s)/illness/treatment(s) that you have had and then on the next page, give its relevant details. Please be sure to add any and all emotional states that you may have encountered during each illness/treatment.

| | | | |
|---|---|---|---|
| Typhoid<br>Cholera<br>Food Poisoning<br>Worms<br>Diarrhea<br>Dysentery<br>Vomiting<br>IBS<br>Recurrent Indigestion | Measles<br>German measles<br>Chicken-pox<br>Small-pox<br>Mumps<br>Whooping cough<br>Meningitis | Malaria<br>Jaundice<br>Liver Disease<br>Spleen Disease<br>Gall Bladder Disease | Pregnancy<br>Sickness during Pregnancy<br>Miscarriage<br>Abortion<br>Infertility<br>Curetting/D&C<br>Prolapsed uterus<br>Laparoscopy<br>Uterine surgery<br>Hysteroscopy |
| Malnutrition<br>Rickets<br>Rheumatism<br>Backache | AIDS<br>Syphilis<br>Gonorrhea etc. | Any heart trouble<br>Blood pressure<br>Blood related disease | Nephritis (Kidney or urine trouble)<br>Diabetes<br>Prostate trouble |
| Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles, Renal Stone, Gall Stones, Cataract etc.<br><br>Indicate mode of anesthesia for each surgery: general or local | Diphtheria<br>Septic Tonsils<br>Sinusitis Bronchitis<br>Lupus<br>Cold (Recurrent)<br>Fever (Recurrent/Intermittent)<br>Chill<br>Pneumonia<br>Asthma<br>Pleurisy<br>T.B.<br>Snoring<br>Parasitic Infections<br>Hodgkin's Disease<br>Cancer (list type accordingly) | | Any serious shock<br>Major grief of any kind<br>Major disappointments<br>Frightening experiences<br>Mental upset<br>Depression or<br>Nervous break down<br>Unusual encounters that you remember |
| Chronic Headaches, Ear Infections, Recurrent/chronic Ear Infections, Numbness, Cramps, Fits, Convulsions Paralysis etc.<br><br>Polio<br><br>Any Lumbar puncture done. | Any major accident or injury to body or head.<br><br>Any occasion of unconsciousness<br><br>Any major bleeding from any part of the body. | | Pimples<br>Boils<br>Carbuncles/Major abscess' with pus<br>Ringworms<br>Fungus<br>Scabies<br>Eczema (give details accordingly)<br>Ulcers on any part of the body<br><br>Eosinophilia (major skin infections/illness due to allergic reactions) |

**List any diseases/conditions not listed above:**

**LIKES AND DISLIKES (please indicate temporal (time wise)/ emotional/ physical states if applicable in Notes):**

Likes and dislikes can often be the main key to determining the correct remedy for a person. Please try to fill in as much as you can and as accurately as you can based on your needs/nature/taste as possible.

Please use

**0** for 'don't care' **1** for 'ok/average' **2** for 'more than average' **3** for 'more than average but can tolerate' **4** for 'extreme' **5** for 'always'(like) or 'never'(dislike)

Example, if you would never eat anything with a bitter flavor, then enter 5 under dislike and enter a short note as to why you would never eat it.

| S.N | | Like | Dislike | Notes | S.N | | Like | Dislike | Notes |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Bitter Flavor | | | | 15. | Cabbages | | | |
| 2. | Extra Salt | | | | 16. | Onions | | | |
| 3. | Sweet | | | | 17. | Warm food | | | |
| 4. | Sour | | | | 18. | Warm drink | | | |
| 5. | Bread | | | | 19. | Cold food | | | |
| 6. | Butter | | | | 20. | Cold drink | | | |
| 7. | Fats | | | | 21. | Acidic Fruits | | | |
| 8. | Milk | | | | 22. | Less Salt | | | |
| 9. | Coffee | | | | 23. | Chalk | | | |
| 10. | Mud | | | | 24. | Tea | | | |
| 11. | Eggs | | | | 25. | Garlic | | | |
| 12. | Spicy food | | | | 26. | Melon Fruits | | | |
| 13. | Meat | | | | 27. | | | | |
| 14. | Fish | | | | 28. | | | | |

If you want to put any other information regarding above mentioned items or any other likes/dislikes and their specifics, please write below:

If you eat meat, which meat do you prefer most and which parts? Dark? Fatty? Lean? Etc.

How often do you eat meat?

If you are a strict vegetarian, then for how long and why? Do you do egg/dairy/etc and why or why not?

Do you eat fish? Which fish most preferred? How often? Do you eat shellfish/crawlers and why/why not?

**PERSONAL COMMENTS**
Please use this section to tell me anything that you feel I should know about you. Nothing is trivial so tell me whatever strikes you as something special about you and that makes you different from anybody else. The information you provide here will help me to be further prepared for our initial consultation and as such, we can maximize our time together to go into more detail where ever needed.

Please remember that, whatever you tell me will be kept in complete confidence and will not be shared with anyone and will be used solely for the purpose of helping the both of us find the best remedy for your situation.

**EXPECTATIONS**
What do you expect from a session with me as your Homeopathic Practitioner?

Have you ever used Homeopathy before and if you have, when?

Why did you go and when did you go and did you feel you find some form of cure from it? Please describe any cures you felt.

Did you ever take any Homeopathic remedies?

If you can remember what you took, please list the remedies here and your initial complaints to your practitioner. If you do not remember the actual remedy name, that is all right, just please try to list what you had explained to your practitioner what your ailments/complaints were at that time.

**Thank you for taking the time to fill out this case history questionnaire form. I look forward to working with you, to help bring you to your optimal health and vitality.**