HOMEOPATHIC CASE -HISTORY FORM

All information given is kept confidential. Please type in the boxes provided

NAME		DATE	
AGE		Tel: Res	
Mother/ Father's name(In case of Minor)		Mobile	
Marital Status		SEX: M/F	
EMAIL:		REFERRED by	
ADDRESS			
DIAGNOSIS		OCCUPATION	

Please describe your complaints. Giving Details on when it began, How it has progressed. Please mention factors that increase or decrease discomforts.

Summary of tests, evaluations done

Tests	Results

Please mention the names and dosage of medicine and supplements that you are on now or have taken in the past

Please mention other therapies the patient is on, include the therapists name, from when the therapy began and changes that you have noted since.

Past history

Every disease, poisoning, drug or accident leaves its mark and remains a weak point in the system, much more than we imagine. Homeopathic treatment takes into account all the 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 treatment you have taken. In the list below underline the names of all major illnesses so far suffered.

Typhoid Cholera food poisoning Worms Diarrhoea Dysentery	Measles German Measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any liver, spleen or gall bladder disease	Women- White discharge Menstrual complaints, Abortions,DNC. Sickness during pregnancy , Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Any venereal disease like Syphilis, Gonorrhoea etc.	Diphtheria, Septic, tonsils, adenoids, recurrent infection- sinusitis Bronchitis- eosinophillia Cold-Fever-Chill, Pneumonia Asthma-Pleurisy-T.B	Urinary troubles Kidney Diabetes mellitus or insipidus Prostrate trouble
Operations: Tonsils, Abdomen Appendix, Piles, Uterus, Renal stones, Gall stones, Phimosis, Hydrocele,Cataract etc. Mode of anaesthesia	Heart trouble High/Low B.P Giddiness	Any Major Accident or injury to body or head. Any occasion of unconsciousness Any major bleeding from Any major part of the body	Skin diseases like Pimples, boils, Carbuncles, Ringworm, Fungus, Scabies, Eczaema, Herpes,Urticaria, Allergy. Ulcers on any part of the body.

Disease suffered from	**Age**	**Duration**	**Completely recovered (Yes/No)**	**Medicines & Treatment taken**	**Any other Particulars**

How is your sleep? Do you feel refreshed in on waking	
Do you remember dreams? Please describe	
Stool- Any constipation or Loose stools.	
Urine- Any recurrent infections	
Sweat/Perspiration	
Any discomforts from weather changes-	
Ever been bitten by any animals or poisonous insects? Any allergic reaction?	
Any reaction to Vaccination taken or illness immediately after	

Family Information

List of major diseases .(Please include Patient,s Parental Grandfather, Parental Grandmother, Maternal Grandfather, Maternal Grandmother, Father, Mother and Siblings) Developmental disorders, Cancer, Diabetes, Psychiatric Disorders, Arthritis, T.B , Bleeding disorders Epilepsy/Fits, Skin Diseases, Asthma, C.V.A/Stroke Hypertension, I.H.D, Kidney disease ,Liver Disease

Dietary Habits- Please specify if you are on any particular diet.
Please put One exclamation mark (!) if you like or dislike the food or the food agrees.
Two exclamation marks (!!) if he/she strongly like/dislike the food or if it strongly disagrees.

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Tobacco				Eggs			
Bitter				Spicy food			
Salt				Meat			
Sweet				Chicken			
Sour				Fish			
Bread				Vegetables			
Butter				Onions			
Fats				Warm food/drink			
Milk				Cold food/drink			
Coffee				Fruits			
Alcohol				Tea			
Cheese				Fried foods			
Ice cream				Anything else			
Chocolate							
Yogurt							

Please mention if any of the food items given above were previously part of your diet and you had a strong like or dislike for the same