

Client's Name –
Client's DOB -

CASE - RECORD

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have 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. HOMOEOPATHIC 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 in selecting 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 these questions 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 homoeopathic 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.

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CONFIDENTIAL

Date:

Name:
(Begin with surname)

Date of Birth -

Address :

Telephone : Home :

Work :

Age :

Sex: Male / Female

Vegetarian / Non Veg. / Egg Veg.

Single / Married / Divorced / Widowed

Occupation (Nature of work):

Education:

Primary Care Provider

Referred to us by:

Signature / initials of Homeopath

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General Consent Form

Name

Date of Birth

Nirupama Desai has been in practice since 1997. She began and continued her practice in India before she moved to US. She is registered with National Center of Homeopathy, Alexandria Virginia and North American Society of Homeopaths (NASH) since 2012 and is certified with the Council for Homeopathic Certification (CCH). She has agreed to abide by the Code of Ethics of each of these organizations.

Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the whole person the homeopath regards the mental and emotional as well as physical aspects as important. A minor aggravation or worsening of some symptoms may occur as a part of the general healing process.

CONFIDENTIALITY

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to him or herself or to others.

CONSULTATION

I authorize discussion of my case notes with other professional homeopaths should assistance in remedy selection and/or symptom analysis be required (for myself or my child) or my best interest be served by such a consultation. In so doing, my right to privacy will be protected by withholding my name and all other identifying information.

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CONSENT

I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself/for my child. I understand that Nirupama Desai is a homeopath and not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check-ups for myself/for my child. I further understand that Nirupama Desai does not diagnose, treat or prescribe for any particular symptom, disease or condition. I understand that she will work on increasing my/my child's general vitality and constitutional strength.

Signature

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PREVIOUS DISEASES & DRUGS USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these 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 treatments you have taken.

In the list below, circle around names of ALL major illnesses so far suffered. On the next page give its relevant details.

Typhoid	Measles	Malaria	Miscarriage.
Cholera	German measles	Jaundice	Abortion
Food Poisoning	Chicken-pox	Any Liver	Curetting
Worms	Small-pox	Spleen or	Sickness during
Diarrhea	Mumps	Gall Bladder	Pregnancy etc.
Dysentery	Whooping cough	Disease	Prolapse of uterus
Malnutrition	Any venereal	Any heart trouble ,	Nephritis (Kidney or urine trouble)
Rickets	Disease like	Blood pressure ,	Diabetes etc.
Rheumatism	Syphilis	Giddiness	Prostate trouble
Backache	Gonorrhea etc.		
Any operation such as Tonsils , Abdomen , Appendix , Hernia , Piles, Uterus , Renal Stone , Gall Stones, Phimosis , Hydrocele , Cataract etc. Mode of anaesthesia : general – local	Diphtheria, Septic Tonsils , Adenoids Recurrent infections – Sinusitis Bronchitis –Eosinophilia Cold 0-Fever-Chill . Pneumonia Asthma – Pleurisy—T.B.		Any serious shock , grief , disappointments, fright , mental upset , depression or nervous break down
Chronic Headaches, Numbness, Cramps, Fits , Convulsions Polio, Paralysis etc. Meningitis –Any	Any major accident or injury to body or head. Any occasion of unconsciousness Any major bleeding from any part of the body.		Skin diseases like Pimples, Boils, Carbuncles,

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Lumbar puncture done.		Ringworms, Fungus, Scabies, Eczema. Ulcers on any part of the body.
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Diseases suffered from	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Any extra remarks of information:

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Mention any drugs, tonics, stimulants etc. that has been used by you at any time in life.

FAMILY INFORMATION

	Relationship	Alive / dead	Age	Diseases	Cause of death
List of major diseases Anaemia Cancer Diabetes Insanity Rheumatism T. B. /Pleurisy Leprosy Epilepsy/fits Bleeding tendency Urticaria Eczema Asthma Paralysis Hypertension Heart trouble	Paternal Grand Father				
	Paternal Grand Mother				
	Maternal Grand Father				
	Maternal Grand Mother				
	Father				
	Mother				
		Diseases Suffered			
	Paternal Uncles				
	Paternal Aunts				
	Maternal Uncles				
	Maternal Aunts				
	Cousin Brother & Sister on Father's side				

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Kidney disease Liver disease etc.	Cousin Brother & Sister on Mother's side	
	Did any of your relatives have trouble similar to yours	

* How many brother –sister are you? (including those who died, if any).

Provide information about them in the table below. Indicate your position by writing 'SELF'.

SR.NO	Brother /Sister	Alive /Dead	Age	Diseases suffered
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

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PERSONAL HISTORY

*About your birth

Did your mother have any problem during pregnancy?

Did she take drugs during pregnancy? What were they?

Was there any difficulty about your birth? Give details.

*At what age did you start?

Teething		Urine Control Bed wetting etc.	
Sitting			
Standing		Eating indigestible like chalk, lime, and earth. Slate-pen	
Walking			
Speaking		Any other problem about Your growth & development	

Tick mark (X) if any animal bites such as:

Dog			Rat			Snake			Scorpion	
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Mention if any other:

Did you take anti-rabies or anti –venom or any other treatment?

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***Vaccination & Inoculations:**

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:

(if married) How is the health of your husband /wife:

*Number of children living and dead. If dead, state causes:

Mention ages of children and their condition of health.

Child's name	Male/Female	Age	Diseases Suffered

Any abortions, miscarriages or still birth?

Your Habits	How much
Smoking	
Snuff	

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Chewing Tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives /Purgatives	
Any other	

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

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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?

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 (X) if you Like / Dislike the food or if the food disagrees. Put two tick mark(X X) 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			

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Butter					Onions			
Fats					Warm food/drink			
Milk					Cold food/drink			
Coffee					Fruits			
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?

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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 color 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?

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?

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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 ? Gonorrhea?

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? Failing erection? Describe.

Any other trouble in sex? Describe in details

FOR WOMEN

Menses : How are the periods ;regular or irregular?

At what age did it start?

Was there any trouble then?

Mention number of days of flow.

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Menstrual flow : Is there any change now in quantity , color , 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 the internal parts coming down?

Is there any white discharge?

If so , mention the nature , color , 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:

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

Any change in color of the skin or spots on any part of the body?

Is there any complaint or abnormality of the NAILS or skin around?

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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 is 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?

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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 complaint 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 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
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	

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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	
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	

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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	
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	

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MIND

It is now universally acknowledged that your mind has tremendous influence on your body . For giving proper treatment it is 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 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, 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?

Of whom? From what symptoms do you suffer when jealous?

In which matters are you impatient?

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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?

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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? r like to remain alone?

How seriously are you affected by disorder and uncleanness in your surrounding?

What are the greatest grieves 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?

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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 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?

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.

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?

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Do you have to uncover any parts?

Circle types of dream that you have

Animal	Robbers	Traveling	Houses	Death, Whose?
Cats-dogs	Thieves	Riding	Fruits	Dead bodies
Horse	Anxious	Flying	Trees	Dead person
Wild animals	Fearful	Swimming	Water	Parts of Body
Snakes	Ghosts	drowning	Snow	Suicide
Being Hungry	Fire	Accidents	Talking	Business
Being Thirsty	Lightning	Falling	Singing	Money
Drinking	Storm	Shooting	Dancing	Day's work
Eating	Rain	Wars	Pleasant	Forgotten work
Vomiting	Romantic	Pain	Praying	Failure /exams
Passing stool	Sexual pleasure	Illness	Religious	Unsuccessful efforts for what
Urinating	Rape	Sickness	Temple	Missing train
Blood – bleeding	nakedness	Mutilations	Church	Being unprepared
Excrements / soiling			God	
Grief	Police	Misfortunes	If any other, specify	
Weeping	Imprisonment	Insecurity	In the space below:	
Vexation	Crime	Danger		

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Quarrels	Murder	Being pursued	
Jealousy	Killing	By whom?	
Insults	Poison	-for what?	
Of people	Of events	Physical Exertion	
Children	Remote	Mental Exertion	
Parties	Recent	Fatigue	
Feasts	Future	Colored	
Marriage	Prophetic	Multi-Colored	

FOR CHILDREN or YOU AS A CHILD

(IN CASE OF ADULTS)

1) 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)	

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Client's Name –
 Client's DOB -

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

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 very upset.

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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 ", " 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 wailing 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 23 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 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 odor, what does it remind you of?
- Does it make the parts sore, and in what way?

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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 you head please mark as shown



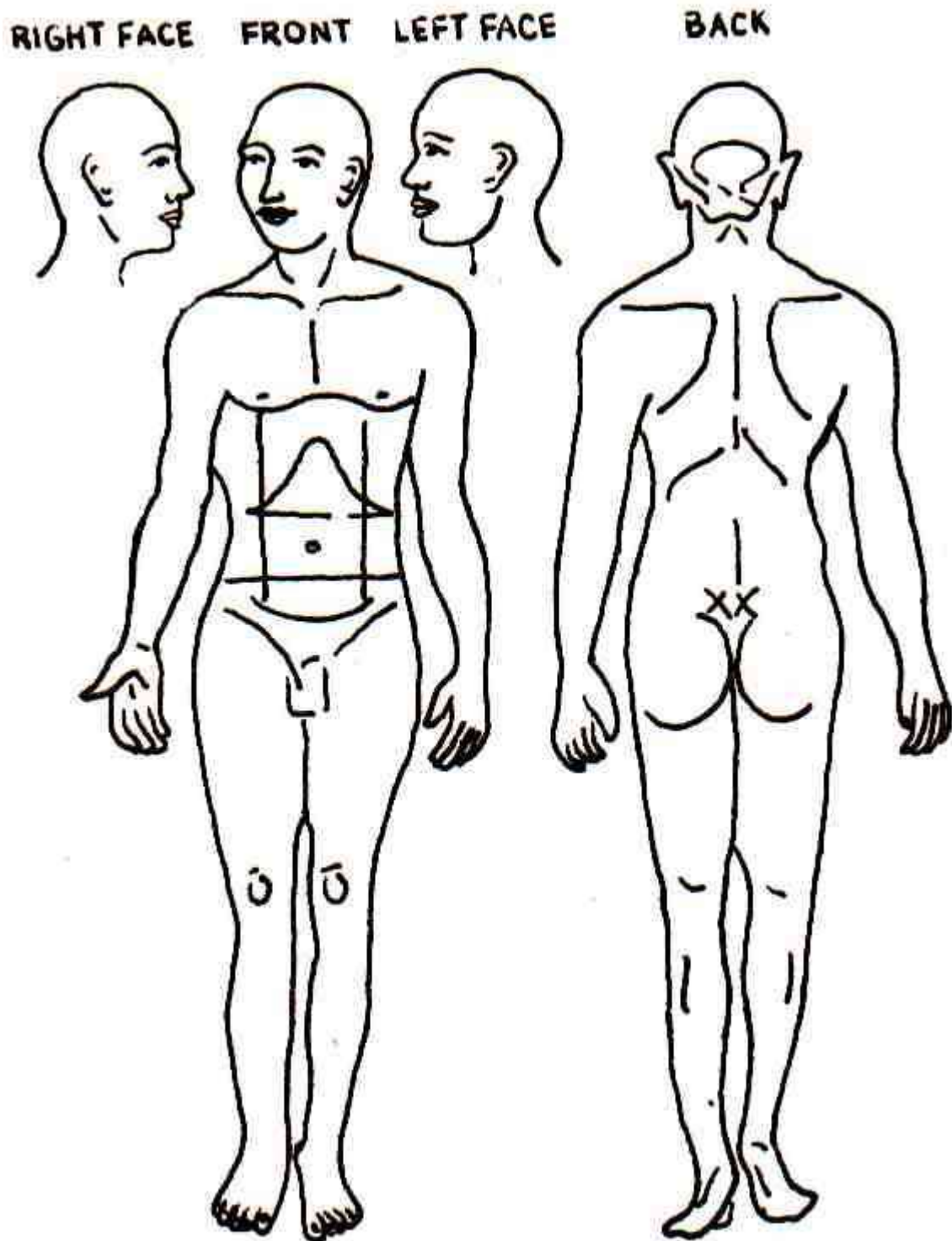
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IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAILS IN THE MANNER DESCRIBED ON **PAGE 23**.

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

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