1. PERSONAL DETAILS

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| --- | --- | --- | --- | --- | --- | --- |
| Title | | | | | | |
| Name | | | : |  | | |
| Surname | | | : |  | | |
| Gender | | | : |  | | |
| Age with Date of Birth | | | : |  | | |
| City with Country | | | : |  | | |
| Profession | | | : |  | | |
| Marital Status | | | : | Single□ Married□ Widowed□ Divorced□ | | |
| Children with their ages | | | : |  | | |
| Complete Postal Address | | | : |  | | |
| With Area Code | | |  |  | | |
| Contact numbers (Code) | | | : |  | | |
| Email | | | : |  | | |
|  | | |  |  | | |
| Lifestyle And Attributes | | | | | |
| http://www.jeevansathi.com/P/IN/zero.gif | | | | | |
| Height | | | : |  | | |
| Weight | | | : |  | | |
| Predominant Diet | | : | Non-Veg □ Veg □ Mixed □ Vegan □ | | |
| Complexion | | : |  | | |
| Body Type | | : | Lean □ Medium □ Heavy □ | | |
| Disabilities if any | | : |  | | |
| http://www.jeevansathi.com/P/IN/zero.gif | | | | | |

|  |  |  |
| --- | --- | --- |
| Education and Occupation | | |
| http://www.jeevansathi.com/P/IN/zero.gif | | |
| Basic Education | : |  |
| Higher Education | : |  |
| Occupation Present & Past | : |  |

1. HISTORY OF PRESENT ILLNESS:

Describe your present complaint in detail at length:

1. Include the location, which part is affected? Eg: Right forehead, lower abdomen, etc.

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1. Describe the type of pain or sensation of discomfort that you feel. Eg: Burning sensation, cramping pain, tingling, numbness, tightness, coldness, etc.

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1. How did the problem begin (origin)? What could be the probable cause? Eg: After exposure to cold wind, after eating oily food, after loss of job, etc.

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1. How long has the problem been there (duration)? Eg: 2 days, 4 weeks, 8-10 years, etc.

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1. What is the progress of the symptoms since they began? Have they become worse or better? If yes, how fast or slow? Have they spread to other parts?

Eg: Started with right-sided headache 4 days ago. Later, spread to left side 2 days ago. Developed nausea after eating yesterday. Today, there is also pain in right ear.

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1. What factors aggravate or worsen your symptoms? Eg: By applying heat or cold; by resting the part or moving it; after sleep; in closed room; Sun exposure, etc. (This info is very important for treatment – so think carefully and reply)

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1. What factors ameliorate your symptoms or make you feel better?

Eg: Applying pressure; Massage; Heat or Ice; lying down; keeping mind busy; etc.

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1. Are your symptoms worse or better at any particular time? Eg: Worse at 11 a.m.; better in evening; worse between 4 and 8 pm; better at night; etc. Are your symptoms worse in any particular season? Eg: “Joint pains occurring in winter season, better in summer”; “Annual eczema in December”

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1. Any other comment …

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1. OTHER ASSOCIATED DISCOMFORTS OR COMPLAINTS:

Describe all other complaints besides the main complaint. Describe each one in the same manner as you describe the primary complaint. (Describe everything that bothers you at length)

Eg: Headache associated with cramping pain in abdomen.

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1. PAST HISTORY: History of any major illness, injury, or operation in the past. Describe its impact on you & at what age you had it?

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| --- | --- |
| Illnesses suffered in the past  Eg: Tuberculosis, Typhoid, Malaria, Jaundice, Ring-worm, Urticaria, Measles, Mumps, Herpes, Chicken-pox, etc… |  |
| Injuries  Eg: Fractures, wounds, bites, etc. |  |
| Surgeries  Eg: Removal of appendix or tonsils or uterus, etc; plating of fracture, etc |  |
| Any other significant history |  |

1. FAMILY HISTORY: History of major illnesses in other family members such as parents, siblings, grandparents, cousins, uncles, aunts, etc.) Eg: Grandparent with history of diabetes OR Maternal aunt with history of Schizophrenia (mention their present age and more details)

|  |  |
| --- | --- |
| DISEASE NAME | FAMILY MEMBERS WITH RELATION TO PATIENT |
| Asthma |  |
| Allergies |  |
| Heart Disease |  |
| Cancer |  |
| Diabetes |  |
| Hypertension |  |
| Stroke/Paralysis |  |
| Tuberculosis |  |
| Any other disease |  |

1. OCCUPATIONAL HISTORY: Type of occupation and what stresses are placed on you by this employment.

|  |
| --- |
| Office □ Factory □ Hotel □ Shop □ Self employed □ Other: |
| Working hours/shift: |
| Nature of Job: |
| Responsibilities: |
| Amount of Stress: |

1. HABITS: (Please specify the quantity, frequency & duration) Eg: Smoking 4 cigarettes a day for the last 2 years.

|  |  |
| --- | --- |
| Smoking |  |
| Alcohol |  |
| Recreational Drugs |  |
| Any other peculiar habit  Eg: Frequent hand washing, repeatedly checking door at night, nail biting, eating undisgestable things like chalk, slate, mud, etc. |  |

1. PERSONAL/SOCIAL HISTORY:

a) RESIDENCE

|  |  |
| --- | --- |
| Describe the area in brief  Eg: Flat on 5th floor of apartment in resident-cum-commercial complex |  |
| Pollution type  Eg: Air pollution, water pollution |  |
| Pollution level or grade | Negligible / Mild / Moderate / High / Very High |
| Climate in the area  Mostly dry, mostly humid, extreme summers and winters, etc |  |
| Do you have any pets? Specify  Eg: German Shepherd dog, Persian cat, tortoise, rabbit, etc. |  |

b) FAMILY history

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Disease |  |
| 1.Father |  |  |  |
| 2.Mother |  |  |  |
| 3.Siblings |  |  |  |
| 4.Siblings |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |

c) APPETITE: Has there been any loss of appetite or increase in appetite since the complaint started?

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d) FOOD ALLERGIES: Are you allergic to any specific food? Eg: seafood, peanuts, eggs, wheat, milk, etc.

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e) CRAVINGS: What types of food or taste do you like very much e.g. Sweets, Salty, Spicy, Eggs, Fish, Curds, Fruits, etc.? To what intensity or degree? Any particular taste that you desire strongly? Eg: Raw, Cooked, Warm, Sweet, Sour, Salty, Spicy, Bitter, etc. Do you add extra salt in your food? Eg: “I have sweets even after meals”; “I must have something sweet”; “I always add extra salt to my food”. What temperature of food do you prefer? Eg: “My food must be hot. I can’t eat it once it becomes cold.”

(For intensity, grade from 1 to 3 where 1 stands for minimum and 3 for maximum intensity)

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f) AVERSIONS: What type of food or taste do you particularly dislike or detest? To what intensity or degree? Any food that doesn’t suit you or causes any trouble? Eg: Aversion to milk, dislikes meat, intolerance to eggs, aversion to sour foods, etc. Eg: “I can’t even have one drop of milk since childhood” OR “If I have an egg, I develop rashes all over my body.”

(For intensity, grade from 1 to 3 where 1 stands for minimum and 3 for maximum intensity)

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g) THIRST: How much water do you consume in a day? How much at a time? At what intervals? Do you prefer your water at room temperature or hot or cold?

Eg: Thirst for small quantities of cold water frequently. Drink about 1.5 liters in a day.

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h) STOOL: Are your bowel movements regular? How many times a day do you pass motions? Any difficulty or pain while passing motions? Do you pass any blood or mucus in stool? Any peculiar smell? Do you have constipation or loose motions? Any other issues related to stools or bowel movements? Do you feel fresh after passing motions?

Eg: Straining for stool with occasional bright red blood. “I have regular motions twice a day” OR “I pass stool after 3 days – I am severely constipated.”

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i) URINE: How many times a day do you pass urine on an average? Any difficulty while passing urine? What is the color of the urine? Any peculiar smell to the urine? Any other issues related to urine or urination? Any burning, itching or other abnormal sensation ?

Eg: Urine dark brown in color since 3 days with fishy smell passed 7 to 8 times in the day and 2 to 3 times at night.

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j) PERSPIRATION: How much do you perspire? Do you perspire more on any particular part/parts of the body? Eg: Armpits, forehead, palms, soles, etc. Does it occur at any particular time or is it related to any particular activity? Eg: At night, after meals. Does it stain your clothes? Any peculiar smell?

Eg: “I have excessive sweating especially on the neck and palms after slight exertion” OR “My sweat smells like garlic” OR “Sweat leaves yellow stains on white clothes”

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k) THERMALS: Do you feel uncomfortable in hot or cold climate? Does sun exposure/fan exposure/AC exposure affect your health & how? Which season do you like the best? In which season does your complaint get worse or better? Do you prefer to cover yourself while sleeping at night or not? Do you prefer the fan/AC or not?

Eg: I prefer winters with AC on during summers. Cannot tolerate direct sun exposure. Need thin blanket to cover during the night.

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| --- | --- | --- | --- |
|  | Summer | Winter | Monsoon |
| Fan desired (No/Slow/Fast) |  |  |  |
| Air-conditioning (Must have/ can tolerate/ cannot tolerate) |  |  |  |
| Covering during sleep  (Thin/thick blanket) |  |  |  |
| Drinks (Hot/cold) preferred |  |  |  |
| Bathing with hot/warm/cold water |  |  |  |
| Sun exposure (No effect/ aggravates/ feels better) |  |  |  |
| Covering of feet (Yes/No) |  |  |  |

l) SLEEP: How many hours do you sleep at night or in the day? Do you feel fresh on waking up in the morning? Is your sleep peaceful or disturbed? Which position do you prefer to sleep in? Eg: On the back, on the stomach, hands stretched up, etc.

Eg: I usually sleep for 6 hours in the night and wake up refreshed in the morning. Sleep is peaceful. I sleep on the sides and back.

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m) DREAMS: What type of dreams you usually get right from childhood? Do you remember them on waking or not? Any recurrent dream? Any persons (alive or dead) seen in your dream often?

Eg: Dreams of being attacked, dreams of snakes, dreams of trying to catch a train or bus but failing to do so, etc.

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n) FEARS: Do you have any strong and persistent fears? Are you scared of any animals, insect, darkness, height, water, robbers, persons, etc. (mention of childhood fears too)?

Eg: Fear of dogs, dark, being alone, heights, crowded places, etc.

(For intensity, use grading from 1 to 3 where 1 stands for minimum and 3 for maximum intensity.)

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1. FOR FEMALES ONLY

a) MENSTRUAL HISTORY:

At what age did you have your first menstrual period?

Are your cycles regular or irregular?

How many days does your period last on an average?

Is the bleeding heavy or scanty?

What is the color of discharge? Eg: bright red, dark red, blackish or pale?

Are the stains difficult to wash off?

Any problems you face before, during, or after your periods? e.g. Backache, headache, excessive irritability, mood swings, etc.

Do you have any white discharge (leucorrhea) before, during or after your periods?

What was the date of the first day of your last period? (LMP)

b) GYNECOLOGICAL HISTORY

Any discharges before, after, or in between menses? Describe the nature, color, odor, consistency, etc.

Methods of contraception used if any

Any existing or past gynecological condition?

c) OBSTETRIC HISTORY

Number of pregnancies

Living children

Abortions (If Any)

Miscarriages

Full term / Premature deliveries

Normal / Cesarean

Sickness during pregnancy: Eg: Excessive vomiting, swelling of feet, varicose veins, etc.

Any medical condition during pregnancy: Eg: Anemia, diabetes, blood pressure, infections etc.

Complications during pregnancy or delivery: Placenta previa, obstructed labor, etc.

Medicines taken during pregnancy if any: Antibiotics, allergy medicines, fever meds, etc.

1. PERSONALITY: How would you describe yourself as a person? Your emotional aspect. How do you feel and react in various life situations in your daily life? Eg: You can describe about your anger. What are the things that make you angry? How do you express your anger? Similarly, about anxiety, sadness, happiness, love, hatred, fears, disappointments, frustration, suspicion, etc. Please describe your nature, behavior, relationships, etc. (Envy, jealousy, suspicion)

Try to portray a picture of your personality without judging as good or bad. (Min. 300 words)

(Full page)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Try to describe your individuality, your uniqueness. Mention about the events in your life that have made a significant impact on your life or left a lasting impression on your personality. You can write about your goals, ambitions, dreams, etc. What differentiates you from others? Are you having any kind of stress at present or in the past? (Min. 200 words)

(Half page)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. CHILDHOOD: How was your childhood? What are your memories about your childhood? Describe your relations with family, friends and teachers at present and in the past. Important or significant events during childhood that you recollect now? (Min. 200 words)

(half page)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. SIGNIFICANT LIFE EXPERIENCES/EVENTS (Eg: Discords, Humiliation; Fights; Deaths; Separations; Divorce; Monetary Loss in business; loss of job, etc.) Describe events that had a major impact on your life. Express how you felt then and now about these events.

(half page)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please note that you may have some symptoms/complaints that may seem unrelated to your main problem/s. From a homeopath's perspective, each symptom is important, however trivial or obsrelief it may seem. Each disrupting symptom – physical, emotional or mental – could be important for selecting your remedy and therefore should be mentioned to us.

Eg: A person coming for treatment of his skin allergy may have dreams of snakes, which on the face of it looks unrelated. However, it may be an important clue for treating the skin allergy.

Describe unusual symptoms like

1. Playing with knives.
2. Laughing at serious matters.
3. Terrified of dogs. If I see a dog, I cross the road.
4. I wash all the bedsheets immediately after the guests who slept on them leave.
5. I feel there is a hole in my brain.
6. My body feels double.

1. DEVELOPMENTAL MILESTONES (Can take help of parents or grandparents)

Birth weight:

When did you start walking?

When did you start talking (first word)?

When did your first tooth erupt?

Were the milestones delayed?

Any other problems or illnesses during early developmental years? Eg: Illness such as jaundice, TB, chickenpox, measles, etc.

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1. ADDITIONAL INFORMATION

|  |  |  |
| --- | --- | --- |
| Hobbies and Interests | | |
| Hobbies | : |  |
| Favorite Music | : |  |
| Favorite color | : |  |
| Interests | : |  |
| Favorite Movies | : |  |
| Favorite Sport  Other Activities | : |  |
| Favorite Cuisine | : |  |
| Dressing Style | : |  |
| http://www.jeevansathi.com/P/IN/zero.gif | | |
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1. ENCLOSURES
2. Medical reports or Consultations
3. Investigation reports
4. Investigation plates: Eg: X-ray, USG, CT scan, etc

[Attach photographs, reports (scanned copies), videos with file name & format in which submitted. Tabulate comparative submissions.]

DISCLAIMERS:

* Treatment given is based solely on the information provided by the patient. It is entirely the patient’s responsibility to provide accurate and complete information.
* All outstation patients, in case of emergency, must immediately seek medical help and visit the local hospital.