**HOMEOPATHIC CASE TAKING FORMAT FOR ADULTS & CHILDREN**

**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 to selection 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 your 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.

**C O N F I D E N T I A L**

**Date:**

|  |
| --- |
| **Name:** |
| **(Begin with surname)** |

|  |
| --- |
| **Address :** |

|  |  |
| --- | --- |
| **Telephone : Residence :** | **Office :** |

**E-mail:**

|  |  |
| --- | --- |
| **Age :** | **Sex: Male / Female** |

|  |  |
| --- | --- |
| **Vegetarian / Non Veg. / Egg Veg.** | **Single / Married / Divorced / Widowed** |

|  |  |
| --- | --- |
| **Occupation (Nature of work):** | **Education:** |

**Height: Weight:**

**Physical appearance (if you wish you can attach your photo especially if you are unable to video chat):**

|  |
| --- |
| **Referred to us by:** |

**SHORT QUESTIONNAIRE**

It will be good if you answer all the questions in the *Long Questionnaire* following this questionnaire. If you feel you do not have that much time, *at least* answer these questions correctly (for any doubts regarding the questions, you can always refer the *detailed* questionnaire given at the end of this questionnaire)

Chief Complaint –

Presenting (Other) Complaint/s –

Past History –

Family History (about your father, mother, sibling, grandparents – both maternal and paternal, children) –

Appetite –

Thirst –

Thermal sensitivity (Sensitive to Heat, Cold, or both) –

Desires –

Aversions –

Sweat –

Urine –

Stool –

Sleep –

Sleep position –

Habits –

Menses (if you are a lady) –

Dreams –

Speed in your day-to-day activities –

Any other thing not mentioned in the questions above –

**VERY DETAILED QUESTIONNAIRE**

**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 suffered so far and on the next page give their relevant details.

|  |  |  |  |
| --- | --- | --- | --- |
| Typhoid  Cholera  Food Poisoning  Worms  Diarrhea  Dysentery | Measles  German measles  Chicken-pox  Small-pox  Mumps  Whooping cough | Malaria  Jaundice  Any Liver  Spleen or  Gall Bladder  Disease | Miscarriage.  Abortion  Curetting  Sickness during  Pregnancy etc.  Prolapsed uterus |
| Malnutrition  Rickets  Rheumatism  Backache | Any venereal  Disease like  Syphilis  Gonorrhea etc. | Any heart trouble ,  Blood pressure ,  Giddiness | Nephritis (Kidney or urine trouble)  Diabetes etc.  Prostate trouble |
| 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 Lumbar puncture done. | 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, Ringworms, Fungus, Scabies , Eczema.  Ulcers on any part of the body. |

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

Any extra remarks or information:

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

**FAMILY INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **List of major diseases**  Anaemia  Cancer  Diabetes  Insanity  Rheumatism  T. B. /Pleurisy  Leprosy  Epilepsy/fits  Bleeding tendency  Urticaria  Eczema  Asthma  Paralysis  Hypertension  Heart trouble  Kidney disease  Liver disease etc. |  | **Relationship** | **Alive /dead** | **Age** | **Diseases** | **Cause of death** |
| 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 |  | | | |
| Cousin Brother & Sister on Mother’s side |  | | | |
|  |  | Did any of your relatives have trouble similar to yours |  | | | |

\* How many brother/s–sister/s 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. |  |  |  |  |

**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 items like chalk, lime, earth. slate-pencil |  |
| Walking |  |
| Speaking |  | Any other problem about Your growth & development |  |
|  |  |

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dog |  |  | Rat |  |  | Snake |  |  | Scorpion |  |

Mention if any other:

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

**\*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 births?

|  |  |
| --- | --- |
| **Your Habits** | **How much** |
| Smoking |  |
| Snuff |  |
| 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).

**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 |  |  |  |
| 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 regarding 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 , urinous.

What colour 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?   
 

**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? 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?

Weak erection? Failing erection? Describe.?

Any other trouble in sex? Describe in detail  
 

**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.

Menstrual flow: Is there any change now in quantity, colour, 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 , 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 :

NOSE & sense of smell:

FACE & Facial expression:

MOUTH & sense of taste:

About LIPS, MOUTH, TONGUE etc.:

TEETH, GUMS e.g. carious teeth m 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 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, 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.

          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 complaint. 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 |  |
| 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 |  |
| 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 |  |

**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 what matters are you anxious?

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? What are you doubtful or suspicious of?

What are you jealous about?

Whom are you jealous about? From what symptoms do you suffer when jealous?

In which matters are you impatient?

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?

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? Or like to remain alone?

How seriously are you affected by disorder and uncleanness (unseemliness) in your surroundings?

What is the greatest grief/s 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?

In your opinion, which aspects of your mind and moods are not agreeable to you? Despite your awareness and maturity, are you unable to change 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:

**S L E E P**

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?

Do you have to uncover any parts?   
 

**Circle types of dream that you have**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Animal  Cats-dogs  Horse  Wild animals  Snakes | Robbers  Thieves  Anxious  Fearful  Ghosts | Travelling  Riding  Flying  Swimming  drowning | Houses  Fruits  Trees  Water  Snow | Death, Whose?  Dead bodies  Dead person  Parts of Body  Suicide |
| Being Hungry  Being Thirsty  Drinking  Eating | Fire  Lightning  Storm  Rain | Accidents  Falling  Shooting  Wars | Talking  Singing  Dancing  Pleasant | Business  Money  Day’s work  Forgotten work |
| Vomiting  Passing stool  Urinating  Blood – bleeding  Excrements / soiling | Romantic  Sexual pleasure  Rape  Nakedness | Pain  Illness  Sickness  Mutilations | Praying  Religious  Temple  Church  God | Failure /exams  Unsuccessful efforts for what  Missing train  Being unprepared |
| Grief  Weeping  Vexation  Quarrels  Jealousy  Insults | Police  Imprisonment  Crime  Murder  Killing  Poison | Misfortunes  Insecurity  Danger  Being pursued  By whom?  -for what ? | If any other, specify  In the space below: | |
| Of people  Children  Parties  Feasts  Marriage | Of events  Remote  Recent  Future  Prophetic | Physical Exertion  Mental Exertion  Fatigue  Coloured  Multi-Coloured |

**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) |  |
| 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 was very upset.

**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 ". Only then 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.

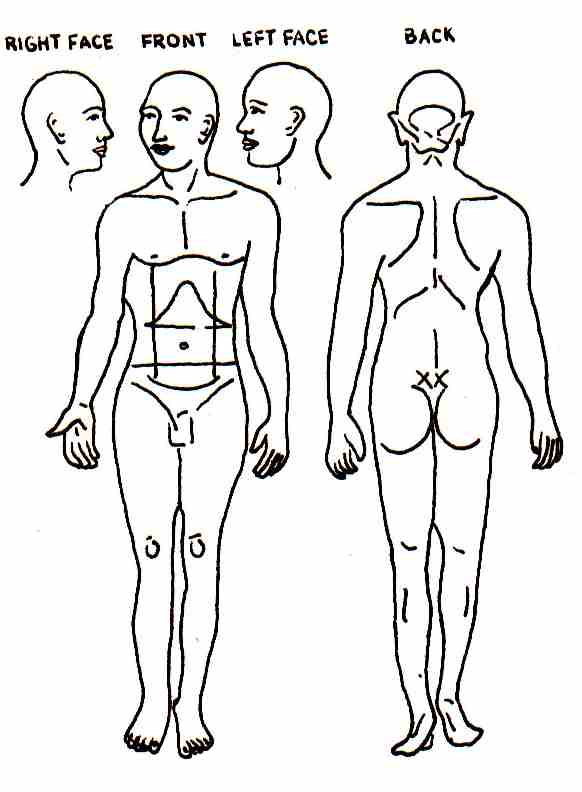
**LOCATION:** Please give the exact location of sensation , pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on page 23 to indicate location.

**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?

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



IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAILS IN THE MANNER DESCRIBED ON PAGES 25-26.   
    
 

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| --- | --- | --- | --- |
| **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** |
|  |  |  |  |