**Case History form for Homeopathic treatment**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Province: \_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Other Telephone: (\_­\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Birth Date: (D/M/Y) \_\_\_\_\_\_\_\_\_\_\_\_ No. of Children: \_\_\_\_\_

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

Family/ Primary Care Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and number of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE READ THIS FIRST BEFORE COMPLETING THIS FORM

You have come here to get well. We are here to select the best medicine for you. 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 problems. 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.

We may be required to ask you a lot of questions. Each one of these questions has a definite meaning and significance for us. 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. All the details will be kept confidential.

**Please complete this form to the best of your knowledge. You may submit a written history or type it at your convenience. You may add extra pages if required.**

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| **Main Issues and Symptoms** |
| Areas Affected: |
| Describe Sensation/Pain/Symptoms: |
| What aggravates the situation:  |
| What provides the relief: |
| Any other symptom/sensation/pain appearing at the same time as the main complaints, such as nausea, gas, hot flash, perspiration: |
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| **Secondary Issues and Symptoms** |
| Areas Affected: |
| Describe Sensation/Pain/Symptoms: |
| What aggravates the situation: |
| What provides the relief: |
| Any other symptom/sensation/pain appearing at the same time of these secondary issue, such as nausea, gas, hot flash, perspiration: |
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| **Additional Personal Data** |
| Description of your physique/body:  |
| Describe your emotional nature and intellectual attainments and aspirations. Indicate to what extent you have been able to realise them (add an additional page if you desire to write more):  |
| Give a clear-cut picture of your relationships with family members, friends and associations:  |
| Give a full description of your life starting from childhood (if you remember any details), teenage days, school life, college/ university life, work life etc.:  |
| Write about any stressors or problems in life and how you handle them: |
| Mention the food you desire and food you avoid, any allergy/ies? |
| How do the weather, sun and temperature affect you? |
| Sleep, Insomnia, average hours of sleep, going to sleep and awake schedule:  |
| Dreams that you often observe:  |
| Sex health:  |
| For females, Menstrual and Obstetric history:  |

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| **Other Illnesses:** |
| Illnesses that you may have suffered in past |
| Family history of any diseases: |

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| **Medical Tests & Reports (if available)** |
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