Case Taking Form

These questions are designed to get the following information from the patient,

1. Mental State of the patient.

2. Physical Ailments.

3. The likely cause for above problems.

4. The modalities like whether the patient feels well or worse in hot weather, cold weather etc., he is relieved by / worsened by hot applications, cold applications etc.

Patients can use this questionnaire for submitting their cases. The effectiveness of remedy selection is directly proportional to the details provided by the patient while replying these questions.

General Information:

Patient Name:

Age:

Contact (Phone or Mobile) Number:

E-mail Address (If you have):

Full Address:

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1. Describe your main suffering?

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2. What other physical sufferings do you have in your body?

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3. What mental sufferings / feelings do you have associated with your physical sufferings?

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4. What exactly do you feel when you are at your worst?

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5. When did it all start? Can you connect it to any past event or disease?

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6. Which time of the day you are worst?

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7. What are the things which aggravate your suffering and which are those which ameliorate the same?

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8. Do your think your sufferings have relation to any external stimuli (like, change of place) or any internal biological changes in the body, like, menses (in females)?

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9. When do you feel better, during hot weather or cold weather, humid or dry weather?

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10. Describe your general mental set up? Are you Moody, Arrogant, Mild, Agreeable, Changeable, Nervous, Suspicious, Easily offended, Quiet, Arguing, Irritating, Lazy etc.

- How do you feel before or during a thunderstorm?

- Do you like being consoled during your tough times?

- Are you sensitive to external stimuli like smell, noise, light etc?

- Do you have any typical habit or gesture like nail biting, causeless weeping, talking to one self etc?

- How do you feel about your friends, family, your children and especially your husband / wife?

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11. What are your fears and do you dream of any situation repeatedly?

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12. What do you crave for in food items and what are your aversions?

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13. How is your thirst: Less, Normal or Excessive?

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14. How if your hunger: Less, Normal or Excessive?

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15. Is there any kind of food which your body can’t stand?

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16. Is your sweat normal or less or more? Where does it sweat more: Head, Trunk or Limbs?

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17. How is your bowel movement and stool type?

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18. How well do you sleep? Do you have a particular posture of sleeping?

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19. Do you think you are able to satisfy your sexual desires in general?

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20. How do you think you are different from others, if at all?

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21. What medications have been taken earlier by you to treat the diseases and do you have any particular symptom surfacing after the medication?

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22. What major diseases are running in your family?

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23. Describe, how do you look like? Describe your overall appearance.

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24. (ONLY FOR FEMALES)

Please answer the following questions; (Please give details of your past menstruation if you have attained menopause).

- Are the periods early, regular or late in general? How long do they last?

- Do you suffer from any kind of physical or mental discomfort before, during or after the periods?

- Is the flow scanty, normal or excessive?

- Is the blood thick bright red or pale watery?

- Do you notice any clots in the flow?
