**Kavitha Holistic Approach, LLC**

**New Client adult case record**



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**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_ Sex: \_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_\_\_**

**Phone: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this office/ whom should we thank for referring:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of family doctor or clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a child, please indicate the following:

Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child lives with you?\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child lives with you?\_\_\_\_\_\_\_

What vaccinations has the child taken?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR HEALTH HISTORY:

What medications do you currently take?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications have you taken in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the previous illnesses? (Please indicate the diagnosis and when it occurred)

Autoimmune disease

Cancer

Heart Disease

High blood pressure

Diabetes

Mental illness

Neurological disorders

Pneumonia

Tuberculosis

Venereal diseases

**Please write any other conditions you suffer from.**

**Any surgeries or hospitalizations:**

**Important Message**

A Homeopathic remedy is mainly selected based on the symptoms you (client / patient) give us. If we are to make a successful Homeopathic remedy selection, 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 condition. All this information enables us for proper selection of the remedy that removes your sickness. The Homeopathic 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 then answer completely. Do not keep anything back. *Remember, whatever you tell us will remain absolutely confidential.*

We may ask you the same questions again and again. This does not mean that your answers are not clear, or that we did not understand them. We have found that by asking some questions repeatedly we are able to get a more clear perception of what your inner experience is, and this is vital to find a good remedy for you.

**THIS QUESTIONNAIRE FORM HAS BELOW MENTIONED SECTIONS:**

* About your past illnesses and family illnesses. Please take time to answer this part with the help of your family members.
* History of your present illness.
* About all the parts of your body.
* Factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
* 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.
* About your sleep and dreams.
* For children (or) you as a child.

**HOW TO DESCRIBE YOUR COMPLAINTS**

Homeopathic system of medicine individualizes the patient and also individualizes the homeopathic medicine. It means treat the patient and not just the disease, so we try to get all the unique distinguishing features of a patient suffering with a disorder which is usually not requested by a medical doctor for diagnosis.

Say for example a person who is suffering with migraine; a medical doctor has 3-5 medicines for this ailment which he prescribes to all the patients suffering with migraine. However in Homeopathy there are 30-50 medicines which are indicated for migraine, so a Homeopath tries to individualize the migraine patient in order to select the most similar or a similimum to the patient. To quote an example: one patient suffering with migraine may feel better by applying pressure to head and other migraine patient gets worse by any kind of pressure so two different medicines needs to be selected for two different patients, this is what individualization in homeopathy means. What seems to be an unimportant symptom or sensation for a patient can be the most important symptom from homeopathic standpoint as it is unique for that particular patient.

Here we are not using the word "medical diagnosis" nor are we trying to do a medical diagnosis, what we are doing is just trying to understand patient's suffering from homeopathic standpoint.

A homeopathic symptom is qualified by 4 points:

* + Location (which part is involved)
  + Sensation (what kind of pain or feeling is experienced)
  + Modalities (what makes you worse and what makes you better)
  + Peculiar, rare or strange symptom that is not related to the problem (e.g. headache relieved by urination).

In homoeopathy, selection of remedy 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" , 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 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.

**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 is felt by 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.

**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 what does it remind you of? Does it make the parts sore, and in what way?

**How your general health has been: Excellent / Good / fair / Poor**

**Do you wake up refreshed in the morning: Y / N**

**What is your energy level on a scale of 1-10?\_\_\_\_\_\_\_\_\_(Increasing scale where 0 means no energy)**

**Body type (circle what applies): Normal / Thin / Stocky / Overweight / Short / Average/ Tall**

**Height \_\_\_\_ ft\_\_\_\_\_in. Weight:\_\_\_\_\_\_\_\_\_lb.**

**Have you had any of these tests:**

|  |  |  |
| --- | --- | --- |
| **Test** | **When** | **Why** |
| **Chest X-ray** |  |  |
| **Kidney X-ray** |  |  |
| **GIT** |  |  |
| **Colon X-ray** |  |  |
| **Gallbladder X-ray** |  |  |
| **EKG** |  |  |
| **Tuberculosis Tests** |  |  |
| **Other tests** |  |  |

**PAST HISTORY - 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.

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

Have you used Homeopathy before? If so, who was your practitioner? Remedies taken? And their Results.

**ANY LABORATORY WORK INFO:**

**FAMILY INFORMATION**

Major diseases that your family members are suffering and cause of death:

Information about your Siblings:

How is the health of your Husband / Wife:

Number of children, their age & about their health?

**PERSONAL HISTORY**

Did your mother have any problem during pregnancy ?

Was there any difficulty about your birth? Give details.

**Vaccinations & Inoculations: (**Any reactions to them)

How were you as a child?

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

|  |  |  |  |
| --- | --- | --- | --- |
| Complaints | Since when | Sensation / feeling / your Experience in relation to disease. | Factors that make you worse or better |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PHYSICAL GENERALS**

How is your appetite?

Hunger? Can tolerate/intolerable

How is your thirst?

What do you crave/desire/love to eat?

Any particular dislikes in food?

Does any food or drink cause any problem?

Do you have any problem regarding your stools?

Any problems in urine?

How much do you sweat?

Where and on what part do you sweat most and does it have any odor or does it stain?

Do you have any problems in the sexual sphere?

How is your sleep?

During sleep (any dribbling, grinding, snoring, talking etc)

Dream? 

**THERMALS:**

Your reaction to Season: Likes summer/winter/ rains/ fall/spring

Your reaction to Fan:

Your reaction to Covering: likes/ dislikes

Your reaction to: heat / cold

Your reaction to Bathing: Hot water/ cold/ seasonal:

**FOR WOMEN**

Menses: How are the periods: regular or irregular?

At what age, did it start?

How long do they last?

Menstrual flow: Is there any change now in quantity , color , smell or consistency?

Any problems: Before Menses:

During Menses:

After Menses:

Any problems during menopause?

Is there any white discharge?

Any itching, excoriation etc. due to discharge?

**ANY OTHER COMPLAINTS :**

HEAD: Do you get headaches?

EYES & Vision:

EARS & sense of hearing:

NOSE & sense of smell:

FACE & Facial expression:

MOUTH & sense of taste:

LIPS:

TEETH, GUMS:

THROAT (including tonsils):

Complaints associated with BACK, LIMBS OR JOINTS? Describe in details:

CHEST/HEART:

COLDS & COUGH:

SKIN/HAIR/NAILS :

DIGESTIVE SYMPTOMS:

WEAKNESS/ENERGY LEVELS:

ONE SIDE OF THE BODY: (Are your troubles one sided? Which one? )

ANY PECULIAR SYMPTOMS:

**FACTORS THAT AFFECT YOU**

Below are 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.

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 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.** If you are not sure just leave it blank.  
      
 

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 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 a 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.

**Describe yourself:**  Write anything that comes to your mind. Your likes/dislikes, strengths/weaknesses, incidences of life that have left impact on you, hobbies etc.

Any fears?

Any anxieties?

How are you in school/ college/office/ house?

How is your anger?

What are you sensitive to?

What makes you cry?

How is your mood?

Your views/philosophies of life?

Any worries? Family/health/ finances/work/ relations

How will you react if someone harms/hurts you?

What makes you happy?

What makes you sad?

How is your memory?

Do you like company? or like to remain alone?

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

Give a clearcut picture of your situation in life and your relationship with each of your family members, friends and associates in work.   
 

If you want to convey any other details, please provide here

**Thank you for your patience & cooperation. We wish to serve you better.**