NEW CASE QUESTIONNAIRE

In order to select the possible medicine for you, I depend on your co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If I am to make a successful prescription, I must know all the details of your sickness and 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 select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order find 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 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.

Try and answer as many of the relevant questions as possible. Take your time and aim at providing the maximum details about each organ / body part and especially to the questions related to your mental, emotional aspects and your personality type.

Mind/Head

Do you suffer from any kind of headache? General or of any particular side, the nature of pain, (throbbing/shooting/pulsating/dull/aching etc)? Any aggravating / ameliorating or triggering cause known, like, exposure to sun or mental exertion or any other cause? Is it better or worse at any time of the day or by walking/ lying down/ pressure/ warmth?

Do you suffer from any affection of scalp, pain/soreness, dandruff, itching, eruptions or falling/premature graying of hair (hereditary or otherwise) etc.?

Your nature is mild/ sensitive/ introvert/ extrovert/ domineering/ short tempered/ emotional/ optimistic/ workaholic/ procrastinating/ anxious/ calm etc. Do you like music or any other serious hobbies pursued?

Your memory and mental performance- good/bad, absent minded, forgetful about anything in particular for ex. Of events (distant or recent), names or numbers or faces etc. It would be helpful if you could share some personal information with us about your nature (what others feel about you and what's your opinion about yourself) and your life especially how do you deal with stress situations in your life? Have you faced any trying or turbulent moments / experiences in the past/ any phases of depression or unnatural behavior? Can you dateback any of your complaints to it?

Is there any history of injury to the head?

Face/Mouth/Throat:

Do you have acne on face/ when did it begin/ do the eruptions leave marks on the face/are these painful and have any discharge of pus or blood/ treatment taken/ any local application/ discoloration on the face/ oily or dry skin? Is there any dryness or cracking of lips (which season)/ bleeding from lips?

Do you suffer from any nasal allergy / Sinusites etc? And do they get converted to lower respiratory tract infections? In an attack of coryza what color is the discharge if any? Is there any history of tonsillitis or tonsillectomy/ any foul smell or bleeding from mouth or gums/ Sensitivity of teeth to hot or cold things/ discoloration of teeth or gums/ decayed or carious teeth (upper or lower jaw, which side, from the roots/crown/ edges)/ Any complaints at time of eruption of teeth/ grinding or clenching of teeth/ lock jaw/ biting of tongue or cheek while talking or eating? Is there any loss of taste/ coating on the tongue/ is the mouth dry or does it remain moist/ ulcers/ cuts/ swelling/ marks of teeth (painful/ bleeding/recurrent)/ stammering or any other complaint?

Chest/Respiratory:

Have you suffered from any respiratory affection like pneumonia/ pleurisy/ tuberculosis/ difficulty in breathing/ suffocative sensation/ dyspnoea/ wheezing (while walking/ ascending or descending stairs/ lying down/ sitting etc.)? If you have cough is it dry, productive, moist, rattling, expectorated easily or with difficulty and what is the color of the expectoration/ pain in chest while coughing? Have you suffered from pain in chest/ which side/ does it radiate to the arm or neck or jaw or back/ injury to the chest or fracture of ribs/ heart disease/ high or low blood pressure/ undergone angiography or angioplasty or bypass surgery/ taking any anti hypertensive or diuretics or any other medication, for how long and with what result?

Appetite/Digestive/Abdomen:

How many meals a day? Has appetite increased or decreased since the disease began? What is the quantity of water intake? How much do u drink at one time? Do you prefer hot/cold/warm drinks? What do you relish eating most (salt, sweet, spicy, sour, fried or any other preferences)? Liking for or aversion to tea/ coffee/ milk and do you like it hot/cold/ trouble from any particular food item? any peculiar craving or aversions?

Motions- frequency/ Which type of digestive disturbance do you get more often loose motions or constipation/ are the stools watery, hard, semi solid, having any undigested food particles/ unusual odor or color of stools, if any/ eructations(no apostrophe) / flatulence/ do they pass easily and relieve/ are they offensive?

Is there any history of gall stones/ jaundice/ hepatitis/ appendicitis or any other complaint? What was the treatment and what was the result of treatment? Have you undergone any surgical procedures like appendicectomy, laparotomy, cholecystectomy, or any other abdominal surgeries? Were there any complications after the surgery? Have the surgical scars healed properly or do they still pain?

Is there any discharge from the umbilicus/ character, color and odor of discharge?

Eyes/Ears/Nose:

Do you wear spectacles or contact lenses? If yes, then nature of the trouble that necessitates their use, for how long, and is any particular eye weaker? Is the vision deteriorating progressively or is stable? Is there any haziness in the field of vision/ watering/ heaviness/ burning/ redness of the eyes/ glaucoma/ cataract? Has any surgical procedure been performed?

Is there any polyp or growth in the nose/ DNS / sinusitis/ allergic rhinitis/sensitivity to smell (of perfumes, cooking food, tobacco, or any other smell)/ loss of smell/blockage of nose (which side)? What was the treatment taken, from where and what was the result? Have you been using any nasal drops and for how long/ history of surgery for removal of polyp or correction of DNS?

Do you have any disturbance in hearing/ sensitivity to loud/slight/sudden/near/distant noises/ pain in the ea/ blockage of any ear associated with cold or any other complaint? Have you been using any eardrops and for how long?

Is there any type of discharge or bleeding from eyes/ears/nose/ character (thick, watery, acrid, bland)/ color of discharge/ any other affection of these organs? Which side of eyes/ears/nose is affected more?

Perspiration: which part of body/ peculiar or offensive odor/staining

FEMALE

Menses began at what age? Have they been regular/ irregular? The present cycle (in how many days the menses reappear)/ duration (how many days do the menses last)/ complaints before, during or after/ character of blood (red, black, odor, staining), amount, quantity of flow/ any clots?

Do you have any discharge per vagina/ what time of the month/ any relation with menstruation/ character of discharge (color/ offensive or of any peculiar odor/ acrid/ bland/ consistency/ staining)/ any itching or discomfort caused by the discharge? How many issues? Were the deliveries normal or caesarean? Any troubles in conception or during pregnancy or after delivery?

Do you have any history of abortions/ at which month/ cause of abortion/ complaints during pregnancy (nausea/ excessive vomiting/ swelling of feet/ backache or any other complaint)? Is there any tendency for urinary infections or burning before, during or after urination/ treatment taken/ unusual color or odor of urine, if any/ frequency of urination (more in night or day)/ involuntary passage of urine (during cough or sleep or any other time)

Limbs/Back:

Do you suffer from any pain in back or limbs/ how did it begin/ character of pain (dull aching/ sharp/ shooting/ stitching/ burning) what side is affected more/ does the pain radiate to any limb from the back/does it radiate from above downwards or below upwards?

Do you have any pain in the shoulders or arms/ which side/ radiates in which direction/ character of pain (dull aching/ sharp/shooting/ stitching/ burning)? What all treatments have been taken and for how long and what was the result of treatment? Is there any peculiar trait of your posture or gait (stooping, hastiness, fidgety, torpidity, tremors, jerking, twitching, involuntary shaking of limbs or facial muscles, deformities or curvatures of spine, fingers, toes etc.)? Is there any history of fractures/ dislocation/ sprains/ spinal surgery/ any complications thereafter/ any foreign bodies in bones or eyes or heart?

Chest/Respiratory:

Have you suffered from any respiratory affection like pneumonia/ pleurisy/ tuberculosis/ difficulty in breathing/ suffocative sensation/ dyspnoea/ wheezing (while walking/ ascending or descending stairs/ lying down/ sitting etc.)? If you have cough is it dry, productive, moist, rattling, expectorated easily or with difficulty and what is the color of the expectoration/ pain in chest while coughing? Have you suffered from pain in chest/ which side/ does it radiate to the arm or neck or jaw or back/ injury to the chest or fracture of ribs/ heart disease/ high or low blood pressure/ undergone angiography or angioplasty or bypass surgery/ taking any anti hypertensive or diuretics or any other medication, for how long and with what result

Skin/Sleep:

What is the texture/ complexion of your skin/ any eruptions, moles/warts- their location, elevated or skin leveled, any particular half of the body affected more right or left (sides are important for us so kindly be more specific regarding the location of all your symptoms), size, color, no., itching or bleeding from them/Any discoloration or white spots on the body/ birth marks? Do your nails have any discoloration / brittleness/ rough surface/ white spots on the nails/ affection of the nail beds (any tendency to suppuration or ingrowing nails)? Do you have any habit of nail biting?

Is there any tendency to varicose veins/ when and how did it begin (e.g. during pregnancy, after menopause, associated with heart, liver or renal troubles or any other cause)? Is there any history of skin affection (like eczema/ psoriasis/vitiligo or any other complaint)/ what was the treatment taken/ local application?  
 Perspiration: more on any particular part of body/ peculiar or offensive odor/staining?

Sleep: refreshing or non-refreshing/ usual position during sleep (on back/ abdomen/ right or left side)/ how long does it take for you to sleep after lying down/ do you wake up during sleep, any particular time, any cause (urination, thirst, dreams, breathing difficulty, pains or any other reason), how long does it take to sleep again/ snoring during sleep? Is there any dependence on sleeping pills? Dreams: any repeated dreams/ pleasant/ amorous/ of animals/ religious/ flying/ of relatives or friends or dead people or death of someone/ falling or any other dreams (pleasant or scary premonitions)/ can you recall your dreams?

Modalities: these are very important for selecting a remedy so kindly fill these carefully...

Are you aware of any triggering, aggravating or ameliorating factors for your trouble(s)? For example:

Does any posture movement improves or worsens your pains or any other trouble, like lying on any particular side right or left/ back or abdomen/ sitting/ standing/ walking/ ascending or descending stairs/ sitting bent forward or any other position?

Does any food item worses (aggravates) or improves (ameliorates) like hot food or drinks/ cold food or drinks/ Ice/ ice creams/ fried food/ spicy food/ sweets/ sour food/wine/beer/ hard liquor. Are there any seasonal aggravations or ameliorations (winters/ summers/ rains) or change of weather (hot to cold / cold to hot)? Do your troubles get better or worse at any particular Time (morning, afternoon, evening, twilight, night, before or past midnight, sunrise to sunset or sunset to sunrise, or any specific time like 4-8 a.m. or p.m./ 3 a.m./ 1-2 a.m. or p.m.)?

Do you feel better or worse by hot, cold application or touch / pressure/ tight bandaging or clothing/ covering/ uncovering/ undressing/ open air/ closed rooms or lifts or crowded places/ before, after or during sleep or bathing or menses/ sexual intercourse/ physical or mental overexertion/ music/ sympathy/consolation/before exams, meeting someone, or during any public performance/ financial or emotional tensions or pressures or any other conditions?