Nihar Arogya Niketan

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PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here 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. HOMEOPATHIC 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 select 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 those 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 homeopathic 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.

CONFIDENTIAL

Date : _____ Name :

_____ (Begin with Surname) Address :

_____
_____
_____
Telephone : Residence :_____ Office :
_____ Age : _____ Sex : Male / Female :
_____ Vegetarian / Non-Veg. / Egg.-Veg.: _____ Single /
Married / Divorced / Widowed_____ Occupation (Nature of Work) :
_____ Education : _____ Referred to us by :
_____

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

(Underline disease you were suffered from)

- Typhoid Cholera Food Poisoning Worms Diarrhoea Dysentery
- Measles German measles Chicken-pox Small-pox Mumps Whooping cough
- Malaria Jaundice Any Liver Spleen or Gall Bladder Disease
- Miscarriage . Abortion Currettings Sickness during Pregnancy etc. Prolapse of uterus
- Malnutrition Rickets Rheumatism Backache
- Any venereal Disease like Syphilis Gonorrhoea 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	Aprox age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Any extra remarks of information :
……
……

At present, what are the medicines (allopathic, homoeopathic) you are taking and details of that. 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**	**Disease**	**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 –sister are you? (including those who died , if any).
Provide information about them in the table below. Indicate your position by writing 'SELF

No.	Brother/sister	Alive/Dead	Age	Disease suffered from
1				
2				
3				
4				
5				
6				
7				

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		Eating indigestibles Like chalk , lime ,earth. Slate-pen	
Standing		Any other problem about Your growth & development	
Walking			
Speaking			

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

Dog:
Rate:
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 :

Vaccine Name/disease	How many time?
Small pox	
Chicken pox	
B.C.G.	
Polio	
Measles	
MMR (Mumps, measles, Rubela)	
Typhoid	
Cholera	
Tetanus	
Any other?	
Any other?	
Any other?	
Any other?	

Was there any reaction or particular trouble after any of above vaccinations of inocculations ?

Marital status:

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:……
……

Any abortions , miscarriages or still birth
?.....

Habits and Addictions:

Your Habits	**How much (Amount/No.) and Since How long (Years/months)**
Smoking	
Snuff	
Chewing tobacco	
Alcohol	
Tea	
Coffee	
Sleeping pills	
Laxatives	
Any others?	
Any others?	

ABOUT YOUR ILLNESES

(A) MAIN COMPLAINTS AND OTHER ASSOCIATED TROUBLES : (AND DETAILED HISTORY OF THE PRESENT ILLNESS. THE ONSET AND COURSE WITH DATES)---------
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(B) ORIGIN OR CAUSE : Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, exposure to cold, heat etc.)?----------
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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 (,) if you Like / Dislike the food or if the food disagrees. Put two tick mrks (,,) if you strongly Like / Dislike the food or if the food strongly disagrees.

Food	Like	Dislike	Disagree		Food	Like	Dislike	Disagree
Bitter					Eggs			
Salt extra					Meat			
Sweet					Fish			
Spicy food					Bread			
Sour					Cabbages			
Butter					Onions			
Fats					Warm food / drink			
Milk					Cold food / drink			
Coffee					Fruits			
Mud / Chalk					Anything else			
Anything?					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 about 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?
- Do you have burning or heat in your palms or soles?

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 details

FOR WOMEN

Menses :

- How are the periods; regular or irregular?
- In what age did it start?
- Was there any trouble then?
- Mention interval between two periods 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 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, bleeding gums. swollen gums :

LIPS : cracked, peeling of skin etc.

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. 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 complaints. For instance if your main complain 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.

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 limb	
In a closed room		Raising the arms	
When thinking of illness		Near Sea	
Full moon / 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	
Belching		Fanning	
Physical exertion		Working in water	

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is absolutely 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 to improve your mental make-up.

Answer freely. Answer frankly, Answer completely.

Are you anxious ? About which matters?
Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.?

Are you doubtful or suspicious? Of what?

What are you jealous about?
Of whom? 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 uncleanliness in your surrounding?

What are the greatest griefs 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. Inspite of 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?

When you are free, what thought come to your mind?

Are you worried or unhappy over any personal, domestic, economical, social or any other condition ?
If so describe in detail :

If asked for 3 desires or wishes in life, what will you ask for?

SLEEP

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?

Please draw something that comes to your mind at present or your favourite drawing :-

(Please draw in separate paper with use of pen, pencil and colors and make photo of it and send them along with this form)

Underline or make color on types of dream that you have

Animals Cats-Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowing	Death, Whose? Dead bodies Dead persons Parts of Body Suicide	Houses Fruits Trees Water Snow
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 Unseccessful efforts for what Missing Train Being unprepared
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing -By whom?	Misfortunes Insecurity Danger Being pursued Poison -For what?	If any other, specify in the space below :	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		

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", or 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 are much less when lying down and covering up the head warmly and much worse when rising up, walking about, or when the head becomes cool," then only 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 26 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 them 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 odour, what does it remind you of?
- Does it make the parts sore, and in what way?