AL- Hakim Homeopathic Center Ltd

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Patient Consent Form Part A

You have come here to get well. In order to do that we depend on your information & cooperation

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 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 makeup. 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.

THIS QUESTIONNAIRE HAS 8 PARTS:

1. About your past 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 how you were 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.

C O N F I D E N T I A L   I N F O R M A T I O N

Date : --

Name (First / Last) : --

Address : --

Telephone Residence : ------------------------------------ Mobile : --

E-mail : ---

Age : --- Sex : ---

Male / Female : ---

D.O.B. : ---

Vegetarian / Non Veg. / Egg. Veg : ---

Single/Married/Divorced/Widowed : --

Occupation (Nature of Work) : Education : --

Questionnaire General (Part A)

PREVIOUS DISEASES & DRUG USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homeopathic treatment takes into account all these details of the past and thus removes all the weak points.

Thus your body is strengthened. Thus 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 illness so far suffered and on the next page give its relevant details.

Please Circle if applicable

01. Typhoid - Cholera - Food poisoning - Worms - Diarrhea - Dysentery

02. Measles - German Measles - Chicken-pox - Small-pox - Mumps -Whooping cough

03. Malaria - Jaundice -Any Liver Spleen or Gall bladder disease

04. Miscarriage - Abortion - Sickness during Pregnancy - Prolapse of uterus

05. Malnutrition - Rickets - Rheumatism - Backache

06. Any Venereal disease like Syphilis Gonorrhea etc.

07. Any Heart trouble - Blood Pressure - Dizziness

08. Nephritis (Kidney or Urine trouble) Diabetes etc. - Prostate trouble

09. Any Surgery such as Tonsils - Abdomen - Appendix - Hernia - Piles - Uterus - Renal stones - Gall stones - Phimosis - Hydrocele - Cataract etc.

10. Mode of Anesthesia : General - Local

11. Diphtheria - Septic Tonsils - Adenoids - Recurrent infections - Sinusitis -Bronchitis - Eosinophilia - Cold-Fever - Chill. Pneumonia - Asthma - Pleurisy - T. B.

12. Any serious shock - grief - disappointments - fright - mental upset - depression or nervous breakdown

13. Chronic Headaches - Numbness - Cramps - Fits - Convulsions - Polio - Paralysis - Meningitis - Any Lumbar puncture done.

14. Any major accident - injury to body or head - Any occasion of unconsciousness -Any major bleeding from any part of the body.

15. Skin diseases like Pimples - Boils - Carbuncles - Ringworm - Fungus - Scabies -Eczema - Herpes - Urticaria - Allergy - Ulcers on any part of the body

FAMILY INFORMATION

Grandfather - Grandmother - Father- Mother - Uncle - Aunt - Cousin Brother & Sister

Did any of your relatives have trouble similar to yours

List of major diseases Relationship Alive / Dead Age Diseases suffered Cause of death

Anemia - Cancer - Diabetes - Insanity - Rheumatism - T. B. / Pleurisy - Leprosy - Epilepsy / Fits - Bleeding tendency

Urticaria - Eczema - Asthma - Paralysis - Hypertension - Heart trouble - Kidney disease - Liver disease etc.

PERSONAL HISTORY

Questions about your birth :

Did your mother have any problem during pregnancy--

Did she take any drugs during pregnancy? What were they---

Was there any difficulty about your birth? Give Details---

At what age did you start Teething---

At what age did you start Sitting --

At what age did you start Standing ---

At what age did you start Walking ---

At what age did you start Speaking ---

Urine control / bed-wetting problem --

Eating indigestible like chalk, lime, earth, slate-pencil etc ---

Any other problem about your growth & development? Speaking --

Tick mark if any animal bites such as: Dog - Rat - Snake - Scorpion ---

Did you take anti-rabies or anti-venom or any other treatment ---

Vaccination & Inoculations

Indicate number of times you were vaccinated for the following :

Smallpox ------- Polio ------ Cholera -------- Measles ------- Triple B. C. G. ------ Typhoid ------ Tetanus -------

Was there any reaction or particular trouble after any of above vaccination or inoculations-----------------

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--

Child’s Name Male/Female Age Disease Suffered ---

Any abortions, miscarriages or stillbirths--

Your Habits How much

Smoking --- Snuff -- -Chewing Tobacco --- Alcohol -- Tea --- Sleeping Pills -- Laxatives / Purgatives -- Drugs

Main Present Complaints and Troubles

(and detailed history of the present illness, the onset and course with dates)

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***Origin of 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, overexposure to cold, heat etc.)

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APPETITE AND THIRST

How is your appetite :

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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 :

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Do you feel any change in your taste and feeling in your mouth :

____

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 ---

LIPS : Cracked, peeling of skin etc --

THROAT (including tonsils) : ---

Any difficulty in swallowing : --

Any trouble in BACK, LIMBS or JOINTS : --

Any abnormality, swelling, numbness, paralysis : --

SKIN : itching, eruptions ulcers, warts, corns, peeling ---

STOOL

Do you have any problem regarding your stools --

When and how many times a day 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, ruinous---

What color 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 ---

Do you experience any sense of heat or cold in any part of your body ---

Do you have burning or heat in your palms or soles ---

CHEST - HEAT - 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 ---

Questionnaire for Adults (PART B)

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 or after sexual intercourse -------------------------

Do you suffer from any sexual disturbance ---

Any habit like (masturbation etc.) in past or present ? How often ---

Any homosexual inclination ---

Did you suffer from any sexually transmitted disease --

Syphilis ? Gonorrhea ? Herpes ? HIV ? --

Did you have increased desire or decreased desire for sex --

What is the method you use for family planning (contraception) ---

Questions For Men

Any difficulty in erection ---

Wanted erection ? Unwanted erection --

Weak erection ? Failing erection? Describe ---

Any other trouble in sex ? Describe in details --

Questions For Women

Menses : How are the periods; regular or irregular ---

At what age did you 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 ---

Color, smell or consistency ---

Are the stains difficult to wash ---

Have you noticed any variation in quality and quantity of flow during menses ----------------------------------

Do you suffer in any way before, during or after menses --

What symptoms did you suffer during menopause --

Is there any white discharge ---

If so, mention the nature, color, consistency and smell of discharge ---

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 ---

Any trouble with breasts ---

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