

## PATIENT PERSONAL DETAILS

CASE NO:

Date: .....

Name : ..... Age : ..... Sex : .....

Address : .....

Phone : (Resi)..... (Mob)..... Email : .....

Alternate Phone Number & Name of person : .....

Date of Birth : ..... Occupation : ..... Marital status : .....

Height : ..... Weight : ..... Blood Group : ..... Qualification : .....

Name of Disease: .....

Present Medication on : .....



## PATIENT'S CONCENT

Please read the information carefully and sign the following to indicate that you have understood and agreed with the information provided to you. Any specific concerns should be discussed with the doctor.

I the undersigned patient and / or responsible relative or person hereby consent to and authorize Dr. Kaushik Gandhi and medical personnel to administer medical treatments, to audio / video record my / his / her case and have no objections it being used for clinical research and other medical studies.

Note : The tape will be stored securely and treated as a highly confidential medical record.

Patient Name / Guardian (for minor) : .....

Date: ..... Signature : .....  I DISAGREE

## Patient Case History Form



Dear Patient, To help us establish you with our Homeopathic treatment, please provide us with your complete health history including all the Physical and Mental symptoms, details about your personal and professional life, your relationships, kindly describe your details to maximum. Any kind of weird explanation are also welcome.  
You can fill up this form in English / Hindi / Marathi or Gujarati language.

MAJOR COMPLAINT/s ( How it Started ? )

OTHER COMPLAINT/s ( Describe in detail )

DESCRIBE YOUR PERSONALITY / NATURE AS A PERSON

DESCRIBE YOUR EMOTIONS

Stress / Tension / Anxiety / Worries / Fears / Phobia / Anger / Sadness / Joyful.

Are you Happy or Unhappy about anything ?

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DESCRIBE YOUR NATURE AS A CHILD / ABOUT YOUR CHILDHOOD

Mother's Medical and Physical History.

Relationships and Life Situation During Childhood.

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DESCRIBE ABOUT YOUR FAMILY AND RELATIONSHIPS

Your Relationship with Family

your Professional Relationship / Relationships at Workplace

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DESCRIBE YOUR SLEEP / SLEEP PATTERN

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DESCRIBE ABOUT YOUR DREAMS. Virtual Dreams / Actual Dreams

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DESCRIBE ABOUT YOUR FANTASIES

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DESCRIBE YOUR SEXUAL SPHERE

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Lesbian, Gay, Hetrosexual, Sexual Dysfunction

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Masterbation, Pre Mature Ejaculation, Unsatisfied Relationship, Weird Fantasies.

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HOW YOU REACT WITH SEA / WATER / RAIN / ANIMALS / NATURE / CLOUDS / SKY / MOUNTAINS / SAND / DESERT/ AIR  
SUN / MOON / STARS / FIRE etc.

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YOUR HOBBIES / PASSION / HABITS

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GENERALITIES

About your Food Habits .....

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Cravings .....

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Appetite .....

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Aversions .....

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Thirst .....

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Addiction .....

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Urine & Stool Habits .....

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Perspiration .....

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Season you are comfortable with Summer / Winter / Monsoon / Dry / Windy / Damp .....

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Past Medical History .....

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Family Medical History .....

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(for womens )Describe about your Menstrual ( Periods ) Cycle .....

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(for womens )Describe about Problems you are facing Before , During and After Menses ( Periods ) .....

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DETAILS AND HISTORY ABOUT YOUR PAST PREGNANCY

History of Miscarriage / MTP / DNC

Dotted lines for writing the details and history of a past pregnancy.

IN WHICH WAY DO YOU WANT US TO HELP AS A HOMEOPATH ?

Dotted lines for writing the way in which the respondent wants help as a homeopath.

WHAT THINGS IN LIFE WHICH YOU CANNOT CHANGE OR WOULD LIKE TO CHANGE ?

Dotted lines for writing things in life that cannot be changed or would like to be changed.

Large vertical dotted lines for writing a detailed response or additional information.