

CONFIDENTIAL

Name: -

Date:

Address:

Pin code:-

Cell No.:

Email:

Skype id:-

Blood Group:

Mother tongue:

Date of Birth:-

Gender:-

Education:-

Occupation (Nature of work):-

Referred to us by:-

About you:

Answer freely. Answer frankly. Answer completely.

1. Describe your complaints one by one in relation to its location, duration, extension, factors which make it worse or better, etc. Which factors are responsible for your sickness according to you? Any incidence, accident, stressful event, or shocking situation?

Answer-

2. Give us details of any previous diseases, when it occurred, which investigations done, what treatment taken? what was outcome of treatment means it cured or partially cured or not cured?

3. Mention any drugs, tonics, and stimulants etc. that have been taken by you at any time in life.

4. Any disease to your parents, grandparents, or blood relatives?

Pl. give details.

5. Any problem you had in your childhood? If yes, pl. describe.

6. Any problem to your mother during pregnancy or at your birth time. If you can get information, pl. detail it.

7. Which vaccines you have received? Was there any trouble after taking any vaccine?

8. Give details of your habits like tea, coffee, alcohol, tobacco, smoking, drugs, sleeping pills, OC pills, herbal medicines for constipation, etc. in how much quantity and frequency?

9. Describe your eating pattern and diet. How is your appetite? When are you very hungry? What happens if you must remain hungry for long time? Can you tolerate hunger? Or you need food immediately? What

do you eat in general? Do you eat hurriedly? Do You feel any change in your taste and feeling in your mouth?

10. Which food substances you like the most? Which you don't like at all? Which substances you like but are not tolerated to your body? What symptoms are developed? Any food allergy?

11. How much water you drink? Normal water or chilled? Recently do you find your thirst has increased or decreased?

12. Any problem about passing stool? Piles or any other thing you feel? Do you need to strain at stool? Is there bleeding or pain while passing motions? When and how many times a day do you pass stool? When is it urgent? Do you have to strain for stool even if it is soft? Do you have belching or passing gas? Describe its character.

13. Any problem in passing urine? Frequent urination? Burning or itching? Involuntary urination? Kidney stone? Any strong smell? Smells 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.

14. Any time you experience headache? What kind of pain? What are other symptoms during headache?

15. How much you sweat? Where and on what part do you sweat most? Palms, soles, face, scalp, etc. Any smell? Does it stains? Delible or Indelible on washing?

16. Any time you feel chills or shivering? Do you experience any sense of heat or cold in any part of your body at any time? Do you have burning or heat in your palms or soles?

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?
- Any habits 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? Since when?
- Do you experience pain in private parts during intercourse?

- What is the method you use for family planning?

For males only

Any difficult in erection? Wanted, unwanted erection? Weak erections? Failing erections? Any other trouble in sexual act? Describe in details.

For females only

Menses: How are the periods, regular or irregular? At 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 are any change now in quantity, color, smell or consistency? Clots?

Are the stains difficult to wash?

Have you noticed any variation in quality & quantity of flow during menses? How & when?

Do you suffer in any way before, during or after Menses? If so, describe.

What symptoms did you suffer during the menopause. Do you feel the internal parts coming down?

Is there any white discharge? If so, mention the nature, color, consistency, and smell of discharge. When and under what circumstances is it more or less?

Is this discharge has any relation to menses?

What is the effect of this discharge on your general feeling? Or on any of your symptoms?

Any itching, excoriation etc. due to discharge? Do you pass any gas from vagina?

Pain or any trouble with breasts? Before or during menses?

Fear, Anger:

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.

What are you jealous about? Of whom?

From what symptoms do you suffer from Jealous?

What makes you angry?

In which matters are you impatient or Hurried?

How long do you remember hurts caused to you by others?

How much revengeful you are?

What are you proud of? Does your pride get easily hurt? Depressed, Brooding etc.?

Do you ever become suicidal? When? If so in What way do you contemplate to end your life? Even then, are you afraid of dying When are you cheerful?

Any unwanted thoughts any time? What are they?

Have you have any imaginary sensations or fears?

What are the greatest grief's that you have gone through in your life?

What are the greatest joys that you have had in life?

In your opinion, which aspects of mind and moods are not agreeable to you?

In spite of your awareness and maturity are you unable to change this aspect?

How does the future look to you?

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 you in sleep.

Describe dreams that you get. Any recurrent dream? Any childhood dreams?

What are your dreams about future?

Tell us 5 things which are most important in life for any person.

Do you draw doodles? Involuntarily while talking on phone, etc.

Pl. draw it and send us.

Draw any picture spontaneously and send us. It should not be pre-decided like you have to draw a car or a tree like that. Draw a picture which is as meaningless as possible.