|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * CASE REFERENCE NO: | | |  | |
| * DATE: | | |  | |
| * DIAGNOSIS: | | |  | |
| * NAME: | | |  | |
| * LAST NAME: | | |  | |
| * FATHER’S / MOTHER’S NAME: | | |  | |
| * AGE: | | |  | |
| * SEX: | | |  | |
| * PRESENT WT. & HT: | | |  | |
| * NATIONALITY: | | |  | |
| * MARITAL STATUS: | | |  | |
| * PROFESSION / OCCUPATION: | | |  | |
| * ADDRESS: | | |  | |
| * TELEPHONE: | | |  | |
| * FAX NO: | | |  | |
| * E-MAIL ADDRESS: | | |  | |
| PRESENT COMPLAINTS (MAIN COMPLAINTS): | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
|  | |  | | |
| ONSET | |  | | |
| * ORIGIN OR CAUSE OF EACH COMPLAINT: | |  | | |
| (PAST HISTORY (PREVIOUS DISEASES AND THEIR TREATMENT) | | | | |
|  |  | | | |
| FAMILY HISTORY (If any of your blood-relatives, i.e. parents, grandparents, siblings, aunts and uncles, suffer or have suffered in the past, from the following): | | | | |
|  | | | |  |
| Allergies: | | | |  |
| * Eczema: | | | |  |
| * Hay Fever: | | | |  |
| * Sinusitis, Cold: | | | |  |
| * Allergic Bronchitis: | | | |  |
| * Asthma: | | | |  |
| * Urticaria: | | | |  |
|  | | | |  |
| * Arthritis: | | | |  |
| * Gout: | | | |  |
| * Osteo-arthritis: | | | |  |
| * Rheumatoid Arthritis: | | | |  |
| * Cancer / Malignancy: | | | |  |
| * Diabetes Mellitus: | | | |  |
| * Hypertension: | | | |  |
| * Coronary Artery Disease, Angina etc: | | | |  |
| * Tuberculosis: | | | |  |
| * Gonorrhoea / Syphilis or STD: | | | |  |
| * Psychiatric & Mental Disorders: | | | |  |
| * Schizophrenia | | | |  |
| * Anxiety Neurosis / Depression: | | | |  |
| * Any other sickness not mentioned above: | | | |  |
|  | | | |  |
| PERSONAL HISTORY | | | |  |
| * Kindly elaborate and mention habits, addictions like alcohol, smoking, tobacco etc. | | | | |
| Appetite: | | | |  |
| * Are you vegetarian or non-vegetarian:? | | | |  |
| * Do you consume eggs? | | | | Yes  No |
|  | | | |  |
| Craving For Foods: | | | |  |
| Mention grades of preference +, ++ or +++. | | | |  |
| For example if you love sweets, mention + or ++ or +++ | | | | |
| * Sweets: | | | |  |
| * Salty food: | | | |  |
| * Do you add Extra salt in your food?: | | | |  |
| * Sour foods / pickles: | | | |  |
| * Seasoned and spicy: | | | |  |
| * Milk: | | | |  |
| * Eggs: | | | |  |
| * Fried and fatty food: | | | |  |
| * Any other cravings in food? | | | |  |
| * Do you dislike sweet or salty or any other specific food? | | | |  |
|  | | | |  |
| How is your Digestion? | | | |  |
| * Any complaints after eating? | | | | Yes  No |
| * Do you experience Fullness of the abdomen, Gas formation or Diarrhea after eating? Do you feel bloated, full and heavy after eating? | | | | Yes  No |
| * Can you remain hungry for hours on end without food? Do you get irritable with hunger? | | | | Yes  No |
| * Does any item of food cause you discomfort, e.g. Acidity, Headache, Flatulence, etc. | | | | Yes  No |
|  | | | |  |
| Thirst: | | | |  |
| How is your thirst, generally? Please mention the grade of thirst? If you are very thirsty, you may mention grades +, ++ or +++ | | | | |
| * How much water do you drink at a time? | | | |  |
| * How many times per day? | | | |  |
|  | | | |  |
| Your preference in drinks: Please mention the degree of craving +, ++ or +++ | | | | |
| * Would you prefer cold / chilled water or drinks even in the height of winter? | | | | Yes  No |
| * Would you like your cup of tea or coffee piping hot? Or just normal warm? | | | |  |
| * How many cups of tea / coffee do you generally drink in a day? | | | |  |
| * Do you have any aversion to any drinks? | | | |  |
|  | | | |  |
| GENERALITIES | | | |  |
| State how you are affected by or how you react to the following: | | | | |
| * 1. Cold in general, cold air, drafts, cold winds, etc. | | | |  |
| * 2. Do you like to cover your head (or wear a cap) when you go out in the cold or when exposed to a draft of cold air? | | | |  |
| * 3. Warmth in general, warmth of bed or of room, external warmth like hot fomentation, etc. | | | |  |
| * 4. Weather: Dry, Cold wet, Rains, Cloudy, etc. | | | |  |
| * 5. Thunderstorms | | | |  |
| * 6. Open fresh air | | | |  |
| * 7. Near the sea / on mountains | | | |  |
| * 8. Eating and Drinking (before, during and after) | | | |  |
| * 9. Fasting | | | |  |
| * 10. Any particular item of food / drinks which adversely affect you or make you sick | | | |  |
| * 11. Closed, Crowded places, Elevators / Lifts, etc. | | | |  |
| * 12. Exertion or Physical strain, Mental strain | | | |  |
| * 13. Lack of sleep | | | |  |
| * 14. In what part of 24 hours do you feel the best or the worst? | | | |  |
| * 15. Do your troubles tend to occur or become worse, periodically (e.g. Daily or alternate days, every week, yearly, during new or full moon etc.) | | | |  |
|  | | | |  |
| STOOL / BOWEL MOVEMENTS | | | |  |
| * Do you regularly have a satisfactory bowel evacuation? | | | | Yes  No |
| * How many times do you move the bowels? When? | | | |  |
| * Consistency: | | | | Whether Well formed  Semi-formed  Very hard Loose? |
| * Odor: | | | |  |
| * Color of stool: | | | |  |
| * Any straining required for passing stools even though stools might not be hard or constipated? | | | | Yes  No |
| * Any urgency for stools (e.g. Do you have to run for stool first thing in the morning or immediately after eating? | | | |  |
| * Any pain, burning, bleeding with stool? | | | | Yes  No |
| * Piles / Fissure / Fistula? | | | |  |
| * Do you have flatus (wind) when passing stool and is the stool noisy and spluttering? | | | |  |
|  | | | |  |
| URINE | | | |  |
| * Frequency, day and night: | | | |  |
| * Any burning during urination? | | | |  |
| * Any smell (Odor) in the urine? | | | |  |
| * Any difficulty in passing urine? | | | |  |
| * Any difficulty in retaining urine? Do you have any incontinence while coughing or sneezing? Is the urine very urgent and you must rush immediately or it will escape? | | | |  |
| * Any associated complaints with urination? | | | |  |
|  | | | |  |
| FOR MEN | | | |  |
| * Any complaints related to the reproductive system? Please give details. | | | |  |
|  | | | |  |
| FOR WOMEN | | | |  |
| * Any leucorrhoeal discharge? Itching, burning or discomfort associated? | | | |  |
| * Any sense of ‘bearing down’ at the time of menses? | | | |  |
|  | | | |  |
| PREGNANCIES | | | |  |
| * How many times have you been pregnant? | | | |  |
| * How many children do you have and what age are they? | | | |  |
| * Did you have smooth pregnancies? | | | |  |
| * Did you take any medication during pregnancy? | | | |  |
| * Did you have normal deliveries? | | | |  |
|  | | | |  |
| MENSES | | | |  |
| * Age of appearance of first period (Menarche) | | | |  |
| * How are the periods? | | | | Regular  Irregular |
| * What is the duration of your period and how many days cycle? | | | |  |
| * How is the flow? – (scanty, heavy, clotted, any odor, color) | | | |  |
| * Any PMT (Pre-menstrual tension)? Do you have any complaints associated with, or before or after your menses? E.g. Moods, Headache, irritability, Anger, Weeping, Depression, Diarrhea or Constipation | | | |  |
| * Any changes in your skin around menses? | | | |  |
| * Any heaviness or pain in breasts before menses? Any nodules in the breast? | | | |  |
|  | | | |  |
| MENOPAUSE: | | | |  |
| * Age of menopause | | | |  |
| * Any associated complaints at the time of menopause e.g. Hot flushes, Palpitation, Anxiety, Depression, etc. | | | |  |
|  | | | |  |
| PERSPIRATION (SWEAT): | | | |  |
| * Do you perspire a lot? | | | |  |
| * Any particular part of the body that you perspire more on? | | | |  |
| * Any strong / offensive odor associated (e.g. Sour smell) with your sweat? | | | |  |
| * Does your perspiration stain your clothes or leave any salty deposits? | | | |  |
|  | | | |  |
| SLEEP: | | | |  |
| * Do you sleep well? | | | |  |
| * Any particular posture in which you lie the most when you sleep? E.g. Lying on the sides (right or left), back or on your abdomen, curled up, etc | | | |  |
| * Do you feel refreshed after sleep? | | | |  |
| * Do you dream while sleeping? | | | |  |
| * Do you sleep-walk, sleep-talk, or grind your teeth in your sleep? | | | |  |
| * Any particular dream that is recalled and often repeated? (E.g. frightening dreams of falling from a height, or being pursued by some men, or dead people or relatives, etc.) | | | |  |
| * Do any of your complaints get worse or better, before, during or after sleep? E.g. Cough or asthma attack that wakes you up at night; migraine on waking in the morning; hot flushes just as you begin to fall asleep. | | | |  |
|  | | | |  |
| SKIN: | | | |  |
| * Any skin problems that you have or had earlier? (E.g. allergies, eczema, fungal infections, pigmentations, acne, etc.) | | | |  |
| * Any itching or discoloration associated with it? | | | |  |
| * Any factors which worsen the skin problem? E.g. Any food item, weather conditions, or washing with warm or cold water. | | | |  |
| * Any treatment taken for the skin? Its details: | | | |  |
| * Any complaints or abnormality of the nails or skin around the nails? | | | |  |
| * Any complaints of hair falling, early graying, dandruff, thinning, etc.? | | | |  |
| * Any warts, moles, birth marks on the body? | | | |  |
| * Does your skin heal normally after an injury or takes very long to heal? | | | |  |
| * Any tendency to form excessive scar tissue (Keloids)? | | | |  |
| * Any tendency for wounds to suppurate (form pus easily)? | | | |  |
|  | | | |  |
| THE MIND: | | | |  |
| (It is very important to give as much details as possible in this section of the Pro forma especially in the case of Chronic Diseases) | | | | |
| * Have you noticed any marked changes in your mental state lately? If so, describe it in detail please. | | | |  |
| * Have you become or are- | | | |  |
| * Anxious / afraid of anything, e.g. being alone, animals, darkness, disease, thieves, robbers, etc. | | | |  |
| * Do you get startled easily by sudden noises, telephone bells, banging of doors, etc. | | | |  |
| * Suspicious, doubting | | | |  |
| * Impatient or hurried and hasty Do you eat hurriedly and there is always a sense of hurry? | | | |  |
| * Offended easily (cannot take any criticism) | | | |  |
| * Are you critical of others, always finding faults | | | |  |
| * Irritable, quarrelsome, violent, etc. | | | |  |
| * Depressed easily, sad, gloomy | | | |  |
| * Timid / Shy / Bashful | | | |  |
| * Jealous or Suspicious | | | |  |
| * Anxious, restless, nervous or excitable | | | |  |
| * Do you feel very anxious and apprehensive before examination, before stressful situations, public engagements, etc.? | | | |  |
| * Are you silent, quiet, reserved or talkative? Do you make friends easily? | | | |  |
| * Are you very affectionate? Do you demand love and warmth from others? | | | |  |
| * Do you cry easily? What makes you cry (grief of others, music, kind words of affection, etc.)? | | | |  |
| * Are you very sympathetic in general and go out of your way to help people in need? Are you easily moved to tears at the plight of others? | | | |  |
| * If someone consoles you when you are upset, does it help or does sympathy towards you makes matters worse? | | | |  |
| * How do you stand and react to contradictions? | | | |  |
| * Are you an authoritative person, always in command and giving orders and expecting them to be followed by everyone around you? | | | |  |
| * Any imaginary fears or feelings? (e.g. That someone might want to harm you or hurt you and that people are against you) | | | |  |
| * How is your memory, power of concentration and mental ability? | | | |  |
| * Do you feel humiliated or hurt easily? Would this give rise to any physical complaints? | | | |  |
| * Are you over conscientious about details, cleanliness, tidiness, punctuality, etc? * Are you a perfectionist by nature, being meticulous, fastidious and even finicky? | | | |  |
| * What is the greatest grief that you have felt in life? Also what are the greatest joys you have experienced in life? | | | |  |
| * Can you mentally relax easily? For instance, can you switch your mind off work, problems, children, etc.? Do you enjoy vacations? Can you totally relax when on a holiday or do thoughts of work or what is happening at home keep bothering you, etc. | | | |  |
| * At work, with colleagues, subordinates or your boss or seniors, how do you equate with them? Would reprimanding or scolding from them upset you tremendously? If so, how? | | | |  |
|  | | | |  |
| PREVIOUS TREATMENT TAKEN | | | |  |
| * Disease Medicine Prescribed System of Therapeutics | | | |  |
| * INVESTIGATIONS | | | |  |
| * LABORATORY TESTS | | | |  |
| * X-RAY, CT-SCANS, MRI, others | | | |  |
|  | | | |  |
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|  | | | |  |
| * Name: | | | |  |
| * Address: | | | |  |
| * Phone: | | | |  |
| * E-mail: | | | |  |
|  | | | |  |