|  |  |
| --- | --- |
| * 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 hastyDo 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:
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|   |   |