*ACUTE CASE RECORD FORM*

*Name:*

*Age:*

*Sex:*

*Occupation:*

*Address:*

*How did you know about us?*

*Have you used Homoeopathy before?*

***Briefly, describe your chief complaints?***

*Fever/chills/cold/cough/pains/diarrhea/weakness/joint pains/breathlessness (etc.)*

***What is the cause of chief complaints according to you?***

|  |  |
| --- | --- |
| ***Emotional cause*** | *Grief/insult/loss/anxiety/any other emotional cause* |
| ***Physical cause*** | *Injury/exertion/lack of sleep/any other cause* |

***Location of the chief complaint:***

*Body part where the problem is:*

*Describe the chief complaint and associated features in detail?*

***Chill/heat/sweat***

*Which part of the body does it begin?*

*Which area is it felt maximum?*

*State your reaction to appetite, thirst, sleep, urination, bowel movements, sweat etc.?*

*Any particular direction of chills/heat/sweat (ascending, descending etc.)?*

***Cough/asthma/respiration***

*Any strong aggravating factors for the above complaints?*

*Any strong ameliorating factors for the above complaints?*

*Loose/dry cough/with pain/without pain etc.?*

*Taste of cough in mouth?*

*Posture – that makes the complaint worse/better?*

***Details of chief complaints:***

*What are conditions of aggravation and amelioration*

***Please fill in the table below regarding the chief complaints:***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Time* — *when is it more*** | ***Temperature* —** ***Reaction to cold and warm*** | ***Posture* — worse or better by*****Lying on back,******Lying on abdomen,******Lying on side etc.*** | ***Reaction to open air/weather*** |
| ***Thirst (changes in pattern)*** | ***Taste (changes in pattern)*** | ***Reaction to eating (↑ or ↓)*** | ***Reaction to sleep (changes in pattern)*** |

***Investigations:***

*CBC:*

*Dengue:*

*Malaria:*

*Covid-19 test:*

*Urine test:*

*Have you been in close proximity with any Covid-19 positive patient?*

***Required:***

***Picture of face:***

***Picture of tongue:***

***Changes at general level (any change from normal):***

***(Write in detail)***

|  |  |  |
| --- | --- | --- |
| ***Thirst (quantity/frequency etc.)*** | ***Menses (absent/painful/ dysmenorrhea)*** | ***Sleep (position/quality-restless/deep etc.)*** |
| ***Reaction to heat and cold (any changes)*** | ***Stools (diarrhea, constipation etc.)*** | ***Urination (↑ or ↓, painful, smell etc.)*** |
| ***Appetite (hunger ↑ or ↓ etc.)*** | ***Cravings for any particular food/drink*** | ***Aversion to any particular food/drink*** |

***Changes in state of mind:***

|  |  |  |
| --- | --- | --- |
| ***What is the reaction to disease?*** | ***Reaction to company and being alone?*** | ***State of mind with respect to time of the day- morning/afternoon/evening/night*** |
| ***Fears/anxieties*** | ***Any other thoughts/feelings*** | ***Dreams*** |
| ***Facial expression*** | ***Dullness/activeness (level)*** | ***Changes in state of mind since symptoms started*** |

***Any other changes or observations:***

*Отправьте вашу анкету на почту – tvoronaya@yandex.ru*