HOMEOPATHIC INTAKE FORM

PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here to get well. Melissa Jude Luca;CHP needs to evaluate your case and select the possible medicine for your body based on its weakness or illness. In order to do that. HOMEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU PROVIDE. If the doctor is to make a successful prescription, she must know all the details of your sickness. She must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up. This information enables her to select the remedy that removes your sickness. The medicine also makes you well as a whole and individualized person.

In order to know all about you, she will be asking you many questions. Each one of these questions has a definite meaning and significance for her. There is not a single question that is useless. Even something that you may think is not connected with your challenges, may be the most important factor in deciding the correct homeopathic medicine. *That is why you must be free and honest and give her the fullest possible information on each question and statement asked below*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell her will remain absolutely confidential.

THIS QUESTIONNAIRE HAS 8 PARTS :

About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.

1. History of your present illness.
2. About all the parts of your body.
3. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
4. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.
5. About your sleep and dreams.
6. For children or how you were as a child.
7. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

C O N F I D E N T I A L

Today's Date: _______________

First Name: ______________________________ **Last Name**: ______________________________________

SS#____________________________ **Male** _______ **Female** _______ **Date of Birth:** _____/_____/_____

Home Address:

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Street

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_ City State Zip

Home Phone: ________________ **Business Phone:**___________________**Cell Phone:** ________________

E-mail: __________________________________ **Education:** _____________________ **Occupation:**

_______________________________**Hours per week:** ____________

Employer: ____

Work Address:

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Street

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_ City State Zip

□ Single □ Married □ Separated □ Divorced □ Widow □ Domestic Partner □ Cohabitating **Live:** □ Alone □

Spouse □ Partner □ Parents □ Children □ Friends

Emergency Contact: ____ **Phone:** _________________

(Name and Relationship)

How did you hear about Cura' Naturale Therapeutic Healing?____

Are you currently receiving healthcare? If yes, where and from whom?

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PREVIOUS DISEASES & DRUG USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homeopathic treatment takes into account all these details of the past and thus removes all the weak points. The goal is to strengthen your body. Therefore, it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illnesses so far suffered and on the next page give its relevant details.

Typhoid Cholera Food poisoning Worms Diarrhea Dysentery	Measles German Measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver Spleen or Gallbladder disease	Miscarriage Abortion Curettings Sickness during Pregnancy Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	**Venereal Disease:** Syphilis Gonorrhoea Chlamydia Herpes	**Heart Trouble:** High/Low Blood pressure Heart Murmurs Palpitation Giddiness	Nephritis (Kidney or urine trouble) Diabetes Prostate Cancer Prostatitis
Operations: Tonsils Abdomen Appendix Hernia Uterus Renal stones Gallstones Phimosis Hydrocele Cataract **Mode of Anaesthesia:** general-local	Diphtheria Septic Tonsils Adenoids Recurrent infections Sinusitis Bronchitis Eosinophilia	Cold-Fever Chill Pneumonia Asthma Pleurisy T. B.	Serious shock, grief, disappointments, fright, mental upset, anxiety, depression or nervous breakdown.
Chronic Headaches Numbness Cramps Fits Convulsions Polio Paralysis Meningitis Any Lumbar Puncture	Major accident or injury to body or head Occasion of unconsciousness Major bleeding from any part of the body	**Skin diseases:** Acne Boils Carbuncles Eczema Urticaria Ulcers on any part of the body	**Skin diseases (con):** Ringworms Fungus Scabies Herpes Allergy

Diseases Suffered From Age
Duration Complete Recovery?

Medicines or Treatments Administered
Any Other Particular

Any extra remarks or information.

Please advise any drugs, tonics, stimulants, etc. that have been used by you at any time in your life and for what purpose.

Any Major Diseases

Anemia

Cancer

Diabetes

Mental Illness

Rheumatism

T.B.

Pleurisy

Leprosy

Epilepsy

Fits

Bleeding Tendency Urticaria

Eczema

Asthma

Paralysis

Hypertension

Heart Disease

Kidney Disease Liver disease

Other

Relationship	Alive/Passed Away	Age	Diseases Suffered	Cause of Death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Paternal Uncles				
Paternal Aunts				
Maternal Uncles				
Maternal Aunts				
Cousin Brother & Sister on Father's Side				
Cousin Brother & Sister on Mother's Side				
Did any of your relatives have trouble similar to yours				

Diseases Suffered

How many brothers - sisters are you? (including those who died, if any) Provide information about them in the table below, Indicate your position by writing 'SELF'.

Sr. No	Brother / Sister	Alive / Dead	Age	Diseases Suffered
1				
2				
3				
4				
5				
6				
7				
8				
9				

PERSONAL HISTORY

About your birth:

Did your mother have any problems during pregnancy? ◻ Yes ◻ No If yes, what occurred? ________________________

Did she take any drugs during pregnancy? ◻ Yes ◻ No If yes, what were they? _________________________________

Was there any difficulty about your birth? Give Details. ____

At what age did you start:

Teething	
Sitting	
Standing	
Walking	
Speaking	

Urine control / bed-wetting	
Eating indigestibles like chalk, lime, earth, slate-pencil	
Any other problems about your growth & development?	

Check if you have had any animal bites:

◻ Dog ◻ Snake ◻ Rat ◻ Spider ◻ Tick ◻ Other, Please list _________________________

Vaccination & Inoculations: Indicate the number of times you were vaccinated for the following:

☐ Small-pox ☐ Polio ☐ Cholera ☐ Measles ☐ Typhoid ☐ Tetanus ☐ Chicken Pox ☐ Mumps ☐ Rubella

Mention in any order: Did you take anti-rabies or anti-venom or any other treatment?

Was there any reaction or particular trouble after any of the above vaccination(s) or inoculation(s)? Give details:_____________________

____

(If married) How is the health of your husband/wife: ___________________________________

Number of children living and dead. If dead, state causes. Mention ages of children and their condition of health.

Child's Name	Male/Female	Age	Diseases Suffered

Any abortions, miscarriages or still births?___________________________________

Habits

Your Habit	How Much?
Smoking	
Chewing Tobacco	
Cocaine	
Marijuana	
Alcohol	
Sleeping Pills	
Laxatives / Purgatives	
Tea	
Soda/Pop	
Other	

MAIN COMPLAINTS AND OTHER ASSOCIATED TROUBLES : (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES).

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APPETITE AND THIRST

How is your appetite? ____________________ When are you hungry? ____________________

What happens if you have to remain hungry for long?

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How fast do you eat? ____________________ How much thirst do you have? ____________________

Any particular time are you especially thirsty?

____________________ Do you feel any change in your taste and feeling in your mouth? ____________________

Please put one check mark (✓) if you Like/ Dislike the food or if the food disagrees. Put two check marks ✓✓, if you strongly like / dislike the food or if the food strongly disagrees.

Taste	Like	Dislike	Disagrees
Bitter			
Extra Salt			
Sweet			
Sour			
Bread			
Butter			
Fats			
Milk			

Coffee			
Mud/Chalk			

Taste	Like	Dislike	Disagrees
Eggs			
Spicy Food			
Meat			
Fish			
Cabbage			
Onions			
Warm Food/Drink			
Cold Food/Drink			
Fruits			
Other			

STOOL

Do you have any problem with your stools? □ Yes □ No If yes, please explain. ______________________________

When and how many times a day do you pass stools? ______________________ When is it urgent? ________________ Do you have to strain for stool? ___________________________ Even if soft? □ Yes □ No

Do you have belching or passing gas? □ Yes □ No Describe its character. ________________________________

How do you feel after passing gas up or down?____

URINATION & URINE

Any problem with urination? □ Yes □ No If yes, please explain. ____ Any strong smell? □ Yes □ No If yes, please explain type of smell. ___________________________________ Do you have any trouble before, during and after passing urine? □ Yes □ No Any difficulty about the flow? □ Yes □ No Slow to start, interrupted, feeble, dribbling, etc.? _______________ Any involuntary urination? □ Yes □ No When?___________

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat? _____________________Where and on what part of the body do you sweat most? ________________

Do you perspire on the palms or soles? □ Yes □ No Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.? □ Yes □ No __________ What is the smell like? e.g. foul, pungent, sour, urinous. ______________________________ What color does it stain the clothing? __________________Is the stain easy to wash off or difficult? _________________________ Any symptoms after sweating?________________________ When do you get fever or chill? _____________________________ What brings it on? _____________________ Do you have burning or heat in your palms or soles? □ Yes □ No Do you experience any sense of heat or cold in any part of your body at any particular time? ________________________________

CHEST - HEAT -

COLD - COUGH

Do you catch colds often? □ Yes □ No If so, please explain. ____

Describe the symptoms, nature of discharge. _______________ Is there any trouble with your CHEST or HEART? □ Yes □ No

Is there any trouble with your voice or speech? □ Yes □ No Is there any difficulty in breathing? □ Yes □ No Do you have a cough? □ Yes □ No Is it more at any particular time? □ Yes □ No

SEXUAL SPHERE (GENERAL)

Any excessive indulgence in sex in past and present? □ Yes □ No Any effect on your health? □ Yes □ No How do you feel after sexual intercourse? ____ Any particular feeling or symptoms appear before, during or after sexual intercourse? _______________________ Do you suffer from any sexual disturbance? □ Yes □ No If yes, please explain. ___________________________

Any habits like (masturbation etc.) in past as well as present? □ Yes □ No If yes, how often? _______________

Any homosexual inclination? □ Yes □ No

Did you suffer from any sexually transmitted disease? □ Yes □ No □ Syphilis? □ Gonorrhoea? □ Herpes? □ HIV? Did you have increased desire or decreased desire for sex? □ Yes □ No

What is the method you use for family planning (contraception)? _______________________________

FOR MEN

Any difficulty in erection? □ Yes □ No Wanted erection? □ Yes □ No Unwanted erection? □ Yes □ No Weak erection? □ Yes □ No Failing erection? □ Yes □ No Describe. _______________________________ Any other trouble in sex? □ Yes □ No Describe in details. _______________________________________

FOR WOMEN

Menses: How are your periods; regular or irregular? ___________ At what age did you start? ______________ Was there any trouble then? □ Yes □ No Timing between two periods. ___________ Number of days of flow. _______

Menstrual flow: Is there any change now in quantity, color, smell or consistency? □ Yes □ No

Are the stains difficult to wash? □ Yes □ No

Have you noticed any variation in quality and quantity of flow during menses? □ Yes □ No

How and when? ____

Do you suffer in any way before, during or after menses? ☐ Yes ☐ No If so, describe. ____________________________________

What symptoms do/did you suffer during menopause? ____

Do you feel internal parts coming down? ☐ Yes ☐ No

Is there any white discharge? ☐ Yes ☐ No If so, mention the nature, colour, consistency and smell of discharge.________

____

When and under what circumstances is it more or less. ____

Has the discharge any relation to menses? ☐ Yes ☐ No

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

________________________________ Any itching, excoriation etc. due to discharge? ☐ Yes ☐ No Do you pass any gas from vagina? ☐ Yes ☐ No

Any trouble with breasts? ____

ANY COMPLAINTS ABOUT:

VERTIGO - Do you have dizziness - vertigo? ☐ Yes ☐ No FAINTNESS: Do you ever feel faint? ☐ Yes ☐ No HEAD : Do you get headaches? ☐ Yes ☐ No EYES & VISION:_______________________________________ EARS & Sense of hearing: ______________________________ NOSE & Sense of smell: ________________________________ FACE & Facial expression: ______________________________ MOUTH & Sense of taste: ________________________________ LIPS, MOUTH, TONGUE: ________________________________ LIPS : Cracked, peeling of skin __________________________ TEETH, GUMS, carious teeth, bleeding gums. swollen gums. ____ THROAT (including tonsils): ______________________________ Any difficulty in swallowing? ☐ Yes ☐ No Do you have any trouble in your BACK, LIMBS OR JOINTS? ☐ Yes ☐ No Describe in detail. ______________________________

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If you have pains, do they shift? ☐ Yes ☐ No In what direction do they extend?____ Is there any abnormality, swelling, numbness, or paralysis in any part of the body? ☐ Yes ☐ No

Is there any complaint of SKIN i.e. itching, eruptions ulcers, warts, corns, peeling, or other? (Describe its nature)

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Any change in color of the skin or spots of any part of the body? ☐ Yes ☐ No

Is there any complaint or abnormality of the NAILS or skins around? ☐ Yes ☐ No

Is there any complaint with the HAIR such as falling, graying, dandruff, dryness, oily, excessive or unusual growth? ☐ Yes ☐ No Do wounds heal slowly? ☐ Yes ☐ No Form keloid? ☐ Yes ☐ No Do wounds tend to form pus? ☐ Yes ☐ No Have you a tendency to bleed? ☐ Yes ☐ No Are your troubles one sided? ☐ Yes ☐ No Which one? ☐ Right ☐ Left Or more on one side? ☐ Right ☐ Left Do they proceed from one to the other side? ☐ Yes ☐ No Or do they alternate or shift? ☐ Yes ☐ No Is there any trembling? ☐ Yes ☐ No When? ______________________ Is there any sense of weakness? ☐ Yes ☐ No Where? ________________ When is it more or less? ____________________ Is it in any particular part of the body? ______________________________

FACTORS THAT AFFECT YOU

Below is a list of things that you are exposed to each day that may affect you in a particular way. Please write in how you are affected by each of the below items. Do you feel worse or better in any way from each of the factors? In what way do they affect you? For instance, take the factor "sun". Suppose by going in the sun you get a headache then write "Headache" opposite to "Sun". Take another example, if in hot weather you feel uneasy, then write "Uneasy" opposite to "Hot Weather" in the column.

In this way, write the effect of each factor on you. Especially write the effect each factor has on your chief complaints. For instance, if your chief complaint is asthma and this is worse when lying on the back then opposite to "lying on the back" write "Asthma becomes worse". Sometimes one factor may make you feel worse in some respect, and better in some other respect. For example, cold air may cause a headache but make you feel better in general. If this is so, please mention this difference clearly. This section is extremely important when evaluating your case. **Do not go through it rapidly and be sure to take your time with each item. Think carefully about the effect of each factor before you make a comment.**

Factor	Effects
Hot Weather	
Cold Weather	
Rainy Weather	
Cloudy Weather	
Change of Season	
Thunder Storm	
Covering	
Warm Bath	
Sun	
Cold Bathing	
Walking	
Running	

Climbing Stairs	
Going Downstairs	

Factor	Effects
Riding in bus, car, or other	
Lying	
Lying on Back	
Lying on Left Side	
Lying on Right Side	
Lying on Abdomen	
Lying with Head Low	
Sitting	
Sitting Erect	
Standing	

Looking Up	
Looking Down	
Looking from High Places	

Factor	Effects
Noise	
Sudden Noise	
Music	
Light	
Strong Smells	
When Constipated	
Before Urine	
During Urine	
After Urine	
Before Menses	
After Menses	
After Sweating	
When Fasting	
Looking from Moving Object	
After Eating	
Drinking	
After Sexual Intercourse	
Dust	
Smoke	
Touch	
Pressure	

Looking from Moving Object	

Massage	
Tight Clothes	

Factor	Effects
Before Sleep	
During Sleep	
After Sleep	
After Afternoon Nap	
Loss of Sleep	
Before Stools	
During Stools	
After Stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	
Effect	
Before Important Engagement	
Before Exams	

When Angry	
When Worried	
When Sad	
After Weeping	

Consolation/Sympathy	

Factor	Effects
In a Crowd	
In a Closed Room	
When thinking about Illness	
Full Moon / New Moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft Air	
Biting or Chewing	
Blowing Nose	
When Alone	
In Company	
Physical Exertion	
Belching	
Passing Gas	
After Hair Cut	
Combing Hair	
Brushing Teeth	

Factor	Effects
Raising the Arms	
Near the Ocean	
Shaving	
Stretching	
Swallowing	
Listening to Others Talk	
Vomiting	
Yawning	
Moving the Eyes	
Opening the Eyes	
Closing the Eyes	
Getting Feet Wet	
Overeating	
Working in Water	
Fanning	
Moonlight	
Opening the Mouth	
Smoking	
Hanging the Limbs	
Other	

MIND

It is now universally acknowledged that your mind has a tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole. In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental make up. Answer freely. Answer frankly. Answer completely.

Are you anxious? □ Yes □ No About which matters? ____________________

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.? ____________________

____

Are you doubtful or suspicious? □ Yes □ No Of what? ____________________

What are you jealous about? ____________________ Of whom? ____________________

From what symptoms do you suffer when jealousy? ____________________

In which matter are you impatient? ____________________ Hurried? ____________________

How long do you remember hurts caused to you by others? ____________ How much revengeful are you? ____________

What are you proud of? ____________________ Does your pride get easily hurt? □ Yes □ No

Depressed, Brooding, etc.? ____________________ Do you ever become suicidal? □ Yes □ No When? ____________ If so in what manner do you contemplate ending your life? ____________________ Even then, are you afraid of dying? □ Yes □ No When are you cheerful? ____________________ Are you sexual-minded? □ Yes □ No Any unwanted thoughts any time? □ Yes □ No What are they? ____________ Have you any imaginary sensations or fears? □ Yes □ No

Do you hear voices, or that you are called, or anything else in this line keeps on occurring in your mind unduly? □ Yes □ No How is your memory? ____________ For what is it poor? e.g. names, places, faces, what you have read ____________ Do you weep easily? □ Yes □ No What makes you weep? ____________________ How do you feel after weeping? ____________________ How do you feel if someone offers sympathy and consolation? ____________________ Are you easily irritated? □ Yes □ No What makes you angry? ____________________ What bodily symptoms do you develop when angry? e.g. trembling, sweating ____________________ Do you like company? □ Yes □ No Or like to remain alone? □ Yes □ No

How seriously are you affected by disorder and uncleanliness in your surroundings? ____________________

What are the greatest griefs that you have gone through in your life? ____________________

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

What activities you deeply like? ____

Are there any matters which you deeply dislike?

____

In your opinion, which aspects of your mind and moods are not agreeable to you. In Spite of your awareness and maturity, are you unable to change these aspects? ____

____

_ Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.

____

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How does the future look to you?

____

_ When you are free, what thoughts come to your mind?

____ Are you worried or unhappy over any personal, domestic, economical, social or any other condition ? If so, describe in detail.

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If asked for 3 desires or wishes in life, what will you ask for?

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SLEEP

Describe your posture in sleep, on the back, side, abdomen, etc.

____ Are you able to sleep in any position? ☐ Yes ☐ No 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 your sleep (Sleepy, Sleeplessness, etc. if so when) ____________________________

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How much do you cover? _________________________ Do you have to uncover any parts? _________________________

Please circle the type of dreams that you have.

Animals	Robbers	Traveling	Houses	Death, Whose?
Cats - Dogs	Thieves	Riding	Fruits	Dead Bodies
Horses	Anxious	Flying	Trees	Dead Persons
Wild Animals	Fearful	Swimming	Water	Parts of a Body
Snakes	Ghosts	Drowning	Snow	Suicide
Being Hungry	Fire	Accidents	Talking	Business
Being Thirsty	Lightening	Falling	SInging	Money
Drinking	Storms	Shooting	Dancing	Day's Work
Eating	Rain	Wars	Pleasant	Forgotten Work

Vomiting Passing Stool Urinating Blood - Bleeding Excrements/Soiling	Romantic Sexual Pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure/Exams Unsuccessful Efforts? For What Missing Train Being Unprepared

Animals Cats - Dogs Horses Wild Animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Traveling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death, Whose? Dead Bodies Dead Persons Parts of a Body Suicide
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom ? - For what ?	**If any other, specify in the spaces below:**	
Of people Children Parties Feasts Marriage	Of events Remote Recents Future Prophetic	Physical Exertion Mental Exertion Fatigue Colored Multi-Colored		

Please draw something that comes to your mind at present or your favorite drawing.

<u>FOR CHILDREN OR YOU AS A CHILD (IN CASE OF ADULT)</u>

1. Please check mark once (✓) if the child or you as child had any of the below qualities. Place two (✓✓) if the symptoms are more intense.

Quality	Check

Obstinacy	
Temper tantrums	
Disobedience	
Aggression	
Hyperactivity	
Destructiveness	
Courage	
Possessiveness	
Competition - Winning Spirit	
Sibling Jealousy	
Any Special Skills	
Unusual Desires (for what?)	
Boasting	
Stealing	
Telling Lies	

Quality	Check
Unusual Fears	
Shyness	
Unusual Attachments (to whom?)	
Habits:	
Bitings Nails	
Thumbing-sucking	
Picking and playing with:	
(a) Mother's body parts	
(b) Shawls, handkerchieves	

(c) Anything else	
Religious	
Dullness of memory	
Slowness (in what?)	
Laziness/Indolence	
Sensitive/Emotional	

2. Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also, describe the dreams the mother got during pregnancy.

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____ 3.

Please describe any other aspects you feel are striking about the child. ______________________

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4. Describe one incident from the child's life when he/she was very upset. ______________________

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HOW TO DESCRIBE YOUR COMPLAINTS

In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homoeopathic physician "I have a headache", "an eruption", or "cough", would not be enough. If you inform her "I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool", then only you have given all the information required for making a good homoeopathic prescription. *The success of the prescription depends, largely, on how detailed your description of the symptoms is.*

We require the following details about your symptoms.

LOCATION: Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on page 24 to indicate location.

SENSATION: Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning, jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on pages 13, 14 & 15. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES: You may have a discharge from ulcers, fistula, eruptions of the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects:

- The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases?
- The consistency; Is it thin or thick, stringy, or clotted?
- Is it like jelly, white of an egg, like water, sticky, forming a scab etc.?
- The odor, what does it remind you of?
- Does it make the parts sore, and in what way?

In the following pages please describe each of your complaints in detail in the manner described on PAGE 22:

Complaint #	Location of Trouble	What exactly do you feel or have here?	What are the factors that make this worse or better?