MEDICAL HISTORY FOR HOMOEOPATHIC TREATMENT OF CHILDREN
Directions for a written submission

INTRODUCTION

1. For finding out a correct homoeopathic remedy for your child, a lot of information with regard to the (i) Complaints (a) Main as well as (b) Subsidiary and (ii) The person of the patient is required.

2. Incomplete information will make correct choice difficult, You are therefore requested to supply all information without keeping back anything as irrelevant or of little importance. The information you supply in the note forms the basis of further enquiry. Full co-operation therefore is requested. All information supplied is, of course, strictly confidential.

3. Since the enquiry can be a time consuming process and a lot of information is being collected, we require to record it systematically. To facilitate this we have evolved a special procedure in which the preliminary study is carried out by a physician specially assigned to this job and when your case record is ready we examine it for instituting treatment. Sometimes more time is required for further detailed processing of information and a study of the child's case. If so, we give you a further suitable appointment for finalizing the line of treatment.

4. We are sure you will co-operate fully with us in rendering you the best possible service.

PRELIMINARY INFORMATION

Please supply the following information about your child as a standard routine:
Name in full, Address & Tel. No. Date of Birth, Sex, Religion/Community/Sect, School.
Standard, Veg/Non-veg/Eggs. Habits : Tea, Coffee, Milk, Chocolates, etc.

Description of the current family set-up, full description pertaining to all the members, their ages, location, work they are doing and the child's relationship with them. Include in your list those who have died stating the age of death, the year and cause of the same. State if the parents have married within the family (i.e. Consanguinous marriage).

The child's daily routine from getting up in the morning to retiring at night. Include in this his/her dietary schedule furnishing full details in respect of the quantities consumed. State the time spent for studies and recreation.

CHIEF COMPLAINT

Describe what bothers the child most. Each trouble should be detailed as under :

1. Full description of the trouble right from the time of onset. Its subsequent development, spread and response to treatment taken. This should give a full idea of :

   (i) Area affected : location, extension, direction of spread, the march of events.

   (ii) Sensation experienced in the area of trouble.

   (iii) Conditions that have brought on the trouble : examine the circumstances that obtained just before or at the time of onset, paying attention to physical as well as emotional factors.

   (iv) Conditions that increase the trouble or those that afford relief.

   (v) Other troubles experienced at the same time along with the main trouble, for example .....perspiration / nausea / vomiting / gas / with pains.

OTHER COMPLAINTS

Describe here all other troubles the child might be having or has experienced in the past. Each should be described fully as suggested above for the `CHIEF COMPLAINT.'

PERSONAL DATA

Give a full account of the following :

(1) Physical description of the child.

(2) (a) Emotional nature : anger, fears, attachments, shyness etc. Mention if you have noted any change in the child's Behaviour / Nature recently.

(b) Intellectual attainments : School performance, Extracurricular activities, Hobbies, etc.

(c) Give a clear-cut picture of the child's relationships with the family members, friends and teachers (school/tuition). Discuss the difficulties experienced by the child in any of these & effects on the child. Financial or interpersonal strains in the family if any (present as well as past).

(3) Reactions to surroundings.

(a) Food : desires and aversions including desire for chalk, earth, etc., foods that do not suit, etc.
(b) General environment : weather, temperature, bath, clothes, covering, etc.
(c) Sleep and dreams.

(4) Growth & Development of the child.

(a) Type of delivery & birth weight. Any health problems soon after birth.
(b) Mother's health & emotional state during pregnancy and after delivery. Breast feeding difficulties if any.
(c) Milestones : State the age at which the child started teething, sitting, walking, talking, etc. Any complaints at that time. Give details of toilet training.

PREVIOUS ILLNESS

Give a resume of the various illnesses the child has had and to what extent these have any bearing on present troubles.

FAMILY HISTORY

Data concerning the parents, brothers and sisters. Also state details concerning the health of grand parents & other blood relatives on both sides.

GENERAL COMMENTS

Include here any items which have not been included above.

ENCLOSURES

1. Referral note from your Physician (if you have been referred) & Old Medical Records.
2. Copies of Reports of Laboratory investigation done earlier..
3. X-ray plates, Sonography, CT Scan etc., if any.

PRESENTATION

Your history is to be filed in the standardized case record which we employ. To facilitate that, you are requested to write in the following way :

1. Take papers of the size 7" (width) x 13" (length).
2. Write in the way the history is printed.
3. Leave margin of 1" at the top for punching.

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40, Parekh Street, Girgaon, Mumbai 400 004.
Tel. : 2386 3479 Fax : 2389 1062