The Healthworks Clinic
Kevin Eakins, ND, Dip Hom, MHMA

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Date of First appointment _____ Reporting time _____

CASE TAKING FORM

PERSONAL DETAILS

Name: _____

Full Postal Address: _____

_____

_____

County:_____ Post Code: _____

Tel No. : _____ Mob: _____

Date of Birth : _____ Place of Birth : _____ Age : _____

E.mail ID : _____ Height: _____ Weight: _____

Status/Present Occupation : _____ Sex : _____

Marital Status : _____ Hobby : _____

Colour of Hair & Eyes: _____ Complexion: _____ Build : _____

Any Peculiarity in Appearance or in the Body :

_____

_____

_____

Medications :

Please state your past and present drug/allopathic conventional medicine history, including any other complementary treatments such as herbalism or acupuncture.

_____

_____

Kevin Eakins ND, dip Hom, dip FCT, The HealthWorks Clinic; T: (086) 811 7605 ; E: kevin@thehealthworksclinic.com

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PRESENT COMPLAINT

If there is more than one current complaint please state the details for each separately, if applicable.:

Please include details of your present ailments (your complaints or concerns have prompted you to make this consultation) and how they affect you?

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

A) Describe exactly the area of the body in which you experience the symptom/s.
Please detail location, extension, radiation or migration/movement of each of the present complaints.

_____

_____

_____

B) Describe the exact nature of the symptoms, including pain and sensation.

_____

_____

_____

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C) Describe the factors, which affect or change your symptoms. This might include weather, food, posture, motion, and pressure. i.e. What makes your symptoms better or worse, other than medication ?

i) In relation to Time [K. R. 1341] & seasons:

ii) In relation to rest, motion [K. R. 1374, 1447], riding in car:

iii) In relation to temperature, weather [K. R. 1348, 1412], damp:

iv) In relation to bathing [K. R. 1335, 1346] :

v) In relation to position [K. R. 1372, 1403], standing, sitting, lying:

vi) In relation to pressure, jar, noise [K. R. 1369 – 79 – 90], light, music:

vii) In relation to eating specific foods,
(e.g. milk, fatty, spicy, vegetables, milk, etc.) [K. R. 481, 1363, 485]:

viii) In relation to sleep [K. R. 1402]. Does any particular position aggravate or ameliorate?:

ix) In relation to menstruation [K. R. 724 – 29 – 33, 1373], before, during, after :

x) In relation to sweat [K. R. 1302]:

xi) In relation to vomiting, perspiration, urine, bowel movement [K. R. 531, 681, 641]:

xii) In relation to coitus [K. R. 693, 695]:

xiii) In relation to anger, grief, fear, consolation [K. R. 57, 51, 44, 16]:

xiv) In relation to new moon, full moon:

xv) In relation to local application (cold, warm, wet):

D) Is there any significant change in any other part of your body or functioning when you experience your symptoms? Or any other symptoms you might experience which are relevant to the above description of your present problem. i.e. Do you have any accompanying symptoms?

_____

_____

E) Which symptom first appeared? What do you think may have contributed or started the symptoms? Any physical (e.g. taking cold, damp exposure, sun, loss of sleep, chemicals); emotional (grief, worry, stress, disappointment, death); diseases in the past; accination or drugs might have started or precipi tated the problem?

_____

_____

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F) When did these changes in your health first appear? How long have you been suffering from each of these problems? How was your recovery?

G) What treatment have you had for each of these problems? How did you feel?

H) Do you have any symptom, which you think may be strange or peculiar?

I) Other Chronic Ailments or Complaints you wish to discuss:

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TOTAL HEALTH PROFILE : HEAD TO FOOT SCANNING OF SYMPTOMS

When completing this section please be guided by the examples given here, but ensure you include any details, which might be relevant to you, but not suggested here. You can also tick (☐) your answer).

1. HEAD

a) ☐ Heat or burning? _____

b) ☐ Perspiration? _____

c) ☐ Vertigo or giddiness? _____

d) ☐ Any other details? _____

2. EYES

a) ☐ Pupils : dilated or contracted? _____

b) ☐ Any blue ring ? Any watering ? _____

c) ☐ Vision? _____

3. EARS

a) ☐ Any discharge? Thick or thin? _____

b) ☐ Colour and odour? _____

c) ☐ Any discharges from the ear in childhood? _____

4. NOSE

a) ☐ Blocked nose? _____

b) ☐ Which side or both? _____

c) ☐ Discharge from nose? _____

d) ☐ Irritation, burning in the nose? _____

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5. MOUTH

a) ☐ Any odour from the mouth? _____

b) ☐ Salivation? _____

c) ☐ Taste? _____

d) ☐ Mouth ulcers? Frequency? _____

6. TEETH

a) ☐ Cavities? _____

b) ☐ Swollen gums? Gum bleeding? _____

c) ☐ Grinding of the teeth? _____

7. THROAT

a) ☐ Any pain? Which side? _____

b) ☐ Any swollen glands or tonsils? _____

c) ☐ Mucus in throat? Hem & hawk or do you constantly have to clear your throat?

_____

8. CHEST/RESPIRATION

a) ☐ Cough? Dry or moist? _____

b) ☐ What aggravates it? _____

c) ☐ When is it aggravated? _____

d) ☐ How it gets better (without mediation)? _____

e) ☐ Any breathing trouble? _____

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9. HEART/CIRCULATION

a) ☐ Any palpitation? Pains, discomfort? _____

b) ☐ What aggravates it and how you feel better? _____

10. STOMACH

a) ☐ Appetite? When do you feel hungry? _____

b) ☐ Any acidity or discomfort? _____

c) ☐ Any burning or heart burn ? _____

d) ☐ Nausea? Vomiting? _____

11. ABDOMEN

a) ☐ Any distension? _____

b) ☐ Which part of the abdomen, right side, left side or middle? _____

c) ☐ Any eructation? Does passing flatus give any relief to the discomfort? _____

d) ☐ Mention the characteristics of any other trouble or pain. _____

12. BOWELS

a) ☐ Please state nature, colour and character of the stools. _____

b) ☐ Odour? _____

c) ☐ Any urging for stool with no satisfactory evacuation? _____

d) ☐ Any tendency towards constipation or diarrhoea? _____

e) ☐ Any mucus or blood in the stool? _____

f) ☐ Any pain before, during or after bowel movement ? _____

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13. RECTUM

a) ☐ Any trouble? _____

b) ☐ Pain? Burning? Discomfort? _____

c) ☐ Piles (swelling)? Fistula (oozing)? _____

d) ☐ Blind or Bleeding piles? _____

14. URINE

a) ☐ Please state the nature, colour and character of the urine. _____

b) ☐ Odour ? _____

c) ☐ Sediment ? _____

d) ☐ Profuse? How frequent is the passing of the urine? _____

e) ☐ Any burning or discomfort? _____

15. PERSPIRATION

a) ☐ Any odour? What part of the body perspires most freely? _____

b) ☐ Does it stain ? _____

c) ☐ Do you perspire more at night or on lying down ?_____

16. JOINTS/EXTREMITIES

a) ☐ Describe any pain in respect of location, sensation, radiation, character and nature.

_____

b) ☐ Past injury? _____

c) ☐ Any burning or sweat? _____

d) ☐ Time and other circumstances which makes the pain worse and better, please detail :

_____

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17. APPEARANCE OF NAILS

a) ☐ Thick/thin? Break easily? _____

b) ☐ Dry/glossy? _____

c) ☐ Ridge, ribbed, wavy ? _____

d) ☐ Concave or convex in appearance ? _____

18. SKIN

a) ☐ Any skin disease? _____

b) ☐ Discharge ? Oozing ? Colour ? Smell ? _____

c) ☐ Itching ? _____

d) ☐ Warts or moles ? _____

e) ☐ What makes itching worse or how does it get better ? _____

f) ☐ Any ointments, lotions, medications used ? _____

g) ☐ Is your skin is generally dry or oily ? _____

h) ☐ Does it heal fast ? _____

19. REPRODUCTIVE SYSTEM

MALE

a) ☐ Sexual desire? Any dwelling on sex? Problems with erectile power? _____

b) ☐ Any abuse? _____

c) ☐ Excessive masturbation? _____

d) ☐ Wet dreams? _____

e) ☐ Frequency ? _____

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FEMALE

a) ☐ Sexual desire? Any dwelling on sex? Problems with arousal? _____

b) ☐ Any prolapse of uterus or erosion of the cervix? _____

c) ☐ Type, regularity of menstruation? Any clotting or odour? Type of pain, if any? _____

_____

d) ☐ When did the menstruation first begin? _____

e) ☐ Miscarriage or terminations? _____

f) ☐ Number of children? _____

g) ☐ Leucorrhoea (Vaginal discharge)? _____

h) ☐ Breast pains/swelling? _____

i) ☐ Pregnancies? _____

j) ☐ Nature of delivery? _____

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MENTAL SYMPTONS: PERSONALITY PROFILE

Please indicate in grades of one + to three +++ which most applies to you.
+++ indicates this applies to me very much. - - - does not apply to me at all.

A. TEMPERAMENT

Absent Minded	Active	Amiable	Angry
Company (Likes/Dislikes)	Energetic	Extrovert	Forsaken
Greedy	Hurried	Indifferent	Impatient
Impetuous	Introvert	Irritable	Jealous
Methodical	Mild	Morose	Neat/Clean
Neagtive (Pessimistic)	Organised	Positive (Optimistic)	Punctual
Quarrelsome	Restless	Sensitimental/Weepy	Slow
Sluggish	Sociable	Stubborn	Suicidal
Suspicious	Sympathetic	Talkative	Untidy/Unclean

B. FEARS

These may be of accidents, animals ,crowds, darkness, death, dogs, heights, incurable diseases, thunderstorm, etc.

_____

_____

C. MEMORY

a) How is your memory for recent events? _____

b) For events of the past? _____

c) Concentration? _____

D. DEPRESSION

a) Onset ? Any particular cause that precipitated ? _____

b) Nature and Character ? _____

c) When worse or better ? _____

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d) Any accompanying symptom? _____

e) What can make you happy ? _____

f) Psychiatric treatment in past ? _____

E. INCIDENTS

a) Your happiest incident in life ? _____

_____ _____

_____ _____

_____ _____

_____ _____

b) Your saddest incident in life ? _____

_____ _____

_____ _____

_____ _____

_____ _____

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MENTAL CAUSATIVE FACTORS:

Which might have affected or affecting you. (Please tick as many as applicable to you)

Abandonment	Sexual Abuse	Violence Abuse	From Being Abused
Abusive Husband	Abusive Parents	Mothers Affection Absent	Anger From Neglected Childhood, Teenage (Not Case For)
After Anger	Anticipation (Effects On Nerves	Anxiety	Apprehends, Sudden Blows, As Had Sudden Beatings As A Child
Bad Tragedies	Bereavement	Betrayal	Boredom
Business Embarrassment	Contradiction	Criticism	Deceived Friendship
Depressing Emotion	Disagreement	Discords Between Chief & Subordinate	Discords, Between Friends
Discords, Between Parents & Children	Domination, Foreign Colonisation, Culture	Domination, Parental	Domination
Emabarrassment	Excitement, Unusual	Failure In Business	Failure
Fear	Feelings, Controlled	Friendship (Deceived)	Fright
Frustration, Demands, Not Fulfilled	Grief (Long Drawn)	Grudges	Guilt, Trapped
Honour, Wounded	Humiliation (Being Criticised)	Humiliation	Indulgence
Insecurity In Children, Need Care Of Parents	Isolation	Jealousy, Professional	Joy
Loss Of Familiar Ground	Loss Of Wealth, Relationship	Love, Conditional	Love, Unhappy
Mental Overexertion	Neglect And Mal-Treatment In Childhood	Bad News	Overstrain, Mental Or Bodily
Parental Arguments	Parental Control	Parental Violence / Arguments	Fit Of Passion
Past History, Dominating Mother, Parents	Perform, To Pressure	Loss Of Possession	Pride
Prolonged History Of Unhappiness	Need For Protection	Abuse By Punishment	Quarrel
Rejection	Reproaches	Reserved Displeasure	Restrictions
Reverses Of Future	Ridicule	Rudeness, Of Naughty Children	Rudness Of Others
Scorned	Seperation, Isolation, Unusual Change In Home / Office	Seperation	Shame
Socio-Cultural Stress	Horrible Stories	Stress, Emotional	Stress, Of Public Performance
Terrors Of Alcoholic Father	Terrors Of Witnessing A Violence	Terrors, Of War	Traumatic Childhood
Ugly, Unloveable	Unfulfillment	Unhappiness, Prolonged	Unloved
Unwanted	Upleasant News	Violence, Unpredicted Mood Of Father	Worry
Wounded (Sensitivity To Redicule)	Wounded Honour	Wounded Pride	

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PERSONALITY PROFILE

Please try and give a general overview of what type of person you are (use ten words to describe yourself) :

PERSONALITY CHARACTERS: TYPE OF PERSON YOU ARE
(Please tick as many as applicable to you)

Absent Minded	Affectionate	Aggressive	Ambitious
Amiable	Anxious	Artistic	Assertive
Bossy	Broods	Bubbly	Careful
Caring	Cautious	Changeable	Collection
Compassionate	Competitive	Lack Of Confidence	Confident
Conscientious	Conservative	Considerate	Conventional
Creative	Discontented	Dutiful	Easy Going
Emotional	Excitable	Extrovert	Family Orientated
Fault Finding	Fearful	Friendly	Fun Loving
Generous	Hesitant	Homely	Honest
Humorous	Impatience	Independent	Fear Insects & Spiders
Intolerant	Introvert	Irritable	Jealous
Kind	Loving	Loyal	Materialistic
Messy	Mild	Moaning	Moody
Lack Of Motivation	Negative Attitude	Optimistic	Outgoing
Passionate	Perceptive	Perfectionist	Pessimistic
Planner	Wants To Please	Precocious	Strong Principled
Private	Avoids Quarrel	Reliable	Resentful
Reserved	Restless	Avoids Risks	Romantic
Follows Routine	Safe Person	Selfish	Sensitive
Sentimental	Serious	Shy	Sincere
Sociable	Social, Friendly	Soft	Desires Solitude,
Stubborn	Superstitious	Sympathetic	Temper Tantrums
Thoughtful	Timid	Strong Sense Values	Whining
Workaholic	Worrier		

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I) NATURE

a) If you could take a week off and money would be no object, what would you do?

b) If you could change one thing about yourself, what would it be?

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HOBBIES

Archery, Boxing	Bingo	Board games	Casinos
Game fishing (Sea fishing)	Creative hobbies (cooking, knitting, drawing, acting)	Fast dancing (rock and roll)	Gambling
Gardening	Golf	Horse riding	Hunting, Martial arts
Lake fishing	Motor racing	Music	Playing Cards
Shopping (excess due to greed)	Shopping (likes changes)	Skiing	Speedway
Swimming	Ten-pin bowling	Traveling	Watching Films (Cinema), TV, Video
Wrestling			

HOMEOPATHIC GENERALITIES: PHYSICAL PROFILE

B. Thermal Reaction

a) What kind of climate do you prefer? _____

What kind of climate do you hate? _____

b) Your desire for fresh air? _____

The type of holiday (warm or cold weather) you would enjoy? _____

c) Which season do you like? _____

d) Do you like to have extra garments (many layers) in winter in compare to others? _____

e) Which is unbearable to you : Summer (warmth) or winter (Cold)?
Please do not correlate perspiration with this ? _____ _____

f) Even in summer do you like to have some warm covering at night/or when you sleep ?
Or you throw off covering even in winter during sleep ? _____

g) If you have an option to choose for living for 5 years either in a very hot country (eg. Dubai with 40 degree celcious and 12 hours of sunsine) or in a cold country (say, Newzealand with 5 degree celcious but 12 hours of bright sunshine) where would it be (money, friends and family are not a problem)?

_____

h) You are going for a short walk on a crispy but bitterly cold day (temperature 0 degree cel.), your friend have put four layers with gloves and hat; how many layers would you put?

_____

i) Do you feel the cold? _____ Do you put your radiator very high in the winter? _____

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I) FOOD PREFERENCES AND APPETITE IN GENERAL

Please indicate by marking between one (1) and eight (8) to indicate degree or order of preference, e.g I love salt and love to add loads on my chips/food (put 1 in the box);then I like savoury-salty-cheesy foods(put 2 in the box); I hate sweet (will go at the end, e.g 8).
[Please put aside any nutritional knowledge and write what you really like and for instance one particular day, you can have anything you like and will have no bad/side effects; and also if you did not have to watch your health or your weight, what would you live on; Please share your desire and NOT diet]:

Group-1

Group-2

Please indicate by marking between one (1) and four (4) to indicate degree or order of preference.
Please share your desire and NOT diet:

Group-3

Please indicate by marking between one (1) and four (4) to indicate degree or order of preference.
Please share your desire and NOT diet:

Any strange food or anything else, you really crave? _____

_____

iii) Thirst Details

a) Hot or cold drinks as a whole? _____

b) Long drinks at short or long interval? _____

c) Sips at frequent interval? _____

d) Thirstless? _____ _____

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(IV)(A) SLEEP

a) Your general sleep pattern ? _____

b) Position/posture during sleep ? _____

(IV)(B) DREAMS

Any recurrent dream or recurrent dreams with the same theme? _____

(V) GENERAL ELIMINATIONS

Any thing that you may think is peculiar in your stool, urine, sweat or menses? _____

_____

(VI) GENERAL NATURE OF TENDENCIES

a) Do you bleed easily or profusely ? _____

b) If you get a cut, does it heal fast or goes septic ? _____

c) Do you have aches and pains in the body or joints ? _____

d) Do your glands get infected or swollen easily from cold or season change ? _____

e) All your problems are generally right or left sided ? _____

(VII) ALLERGIES

_____

_____

(VIII) PAST MEDICAL HISTORY

Please narrate any past diseases and surgeries and accidents :

Asthma	Burns	Chicken pox	Eczema	Glandular Fever	Injury or Fractures	Measles	Malaria
Meningitis	Mumps	Polio	Skin disease	Tonsillitis	Tuberculosis	Typhoid	Venereal disease

(IX) ADDICTION

_____

_____

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(X) YOUR MILE-STONES

a) Your first mile-stones, e.g. First cutting of teeth, first walking, first talking; were they regular on time or delayed ?

_____

b) Traumas : Physical and Emotional _____

c) Vaccination History _____

d) How many and what type of vaccinations or inoculations have been given? _____

_____

e) Note the reaction to each, if any ? _____

(XI) FAMILY MEDICAL HISTORY

a) Any relevant medical history, if known or cause of death if deceased

Mother : _____ Grandfather : _____ Grandmother :_____

Father : _____ Grandfather :_____ Grandmother :_____

Brothers : _____ Sisters : _____

b) Any information regarding family tendencies. E.g Rheumatism, blood pressure, insanity, piles, diabetes, cancer, venereal disease.

_____

c) Any contact with or nursing tubercular or similar patients.

_____

(XII) PREGNANCY HISTORY

a) Any significant occurrences to the mother during the gestation / pregnancy period (your mother's pregnancy with you) :

Any asphyxia (loss of oxygen)	Any birth injuries	Anxiety
Details about the delivery	Disappointment	Disease
Falls or accidents	Fears	Forceps
Fright	Grief	Medications
Normal. Per vagina	Shock (Frequent)	Ultra sound scannings (Repeated)

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(XIII) Any other details which you consider important to be Taken into account for your homoeopathic prescription

_____

_____

_____

(XIV) Never been well since

Is there any incidence e.g. Physical (injury, exposure to damp, cold); emotional (grief, disappointment, stress etc.); disease or abuse of drug/medications; since then your health has changed : Never Been Well Since :

_____

_____

_____

(XIV) Your Life Story

Please detail your important incidences that might have affected your life. Give more emphasis on the following aetiologies or causative factors: (a) Physical (injury, exposure to damp, cold, any incidences and you are never been well since); (b) emotional (grief, disappointment, stress etc.); (c) disease (any major illness and you are never been well since) or (d) use or abuse of medications/drugs (conventional and recreational):

_____

_____

_____

Age group: 0 to 10 years:

Physical:_____

Emotional: _____

Disease: _____

Drugs: _____

Age group: 10 to 20 years:

Physical: _____

Emotional: _____

Disease: _____

Drugs: _____

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Age group: 20 to 30 years:

Physical:_____

Emotional: _____

Disease: _____

Drugs: _____

Age group: 30 to 40 years:

Physical: _____

Emotional: _____

Disease: _____

Drugs: _____

Age group: 40 to 50 years:

Physical:_____

Emotional: _____

Disease: _____

Drugs: _____

TO WHOM IT MAY CONCERN
(HOMOEOPATHIC CONSULTATION WITH KEVIN EAKINS)

I understand that Homoeopathy is a safe complementary system of medicine and it works gently to stimulate the body's own healing power.

I understand that there is no recommendation by the Homoeopath to stop, vary, reduce or change any medication prescribed by my G.P. and/or Consultant and if I intend to do so, that will be at my own choice and my concerned Homoeopath will not be liable for any consequences thereof.

Signature_____ Date _____, 201

(Name and Full Postal Address) _____

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FOR PRACTITIONER'S USE

1) Investigation done before / after homepathic treatment :

_____

_____

2) Clinical details & Provisional diagnosis :

_____

_____

3) Miasmatic diagnosis :

_____

_____

4) Constitutional remedy :

_____

_____

5) Satellite medicines :

_____

_____

6) Computer analysis :

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Kevin Eakins ND, dip Hom, dip FCT, The HealthWorks Clinic; T: (086) 811 7605 ; E: kevin@thehealthworksclinic.com

IMPORTANT :

Thorough completion of this form with all your symptoms will increase the quality and speed of recovery.
So please complete the form to the best of your knowledge any and all details are useful to establish your correct prescription.

The Healthworks Clinic
Kevin Eakins, ND, Dip Hom, MHMA

CONFIDENTIAL

PRESCRIPTION PROFILE

Date	Report after last medication and the present Prescription done on the basis of :	Treatment

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