To: OPTIMUM HEALTH CENTER

I,_____ (ID/PPT#_____), understand that Dr. Yuan Tai Ming, Alexander, who is the clinic director of Optimum Health Centre, has been qualified as Doctor of Chiropractic in Canada from Canadian Memorial Chiropractic College in 1982; as Doctor of Naturopathy in Canada from Ontario College of Naturopathic Medicine in 1986; and received the Diploma in Homeo-Therapeutics (D.HT) from Bengal Allen Medical Institute in India in 1987. Dr. Alexander Yuan is the vice-president of the Asian Homeopathic Medical League and is the vice-president and consultant of the World Federation of Chinese Naturopathy.

I also understand that, Dr. Alexander Yuan, Homeopath / Naturopath / Registered Chiropractor / Listed Chinese Medicine Practitioner, is not registered as an Allopathic medical practitioner under the Medical Registration Ordinance (Chapter 161) section 14 and 14A in Hong Kong.

All the products provided by Optimum Health Centre are for the promotion of health only. None of the products is for use in:

(a) the diagnosis, treatment, mitigation, alleviation or prevention of disease or any symptom thereof;
(b) the diagnosis, treatment, mitigation, alleviation of any abnormal physical or physiological state or any symptom thereof;
(c) altering, modifying, correcting or restoring any organic function,

in human beings or in animals.

_____ Date _____

Patient's signature

Purpose for consultation:

☐ **Just look after the existing health concern**
☐ **To improve myself constitutionally as a whole**
☐ **Anti-aging to achieve optimum health**

Indicate your general feeling well-being at this moment,
(worst: 0 ⇔10: best): _____

大 康 自 然 健 康 中 心
OPTIMUM HEALTH CENTRE

香港銅鑼灣渣甸街 54-58 號富盛商業大廈二樓
2/F, Prosperous Commercial Building, 54 - 58 Jardine's Bazaar, Causeway Bay, Hong Kong
電話 Tel: (852) 2577-3798 圖文傳真 Fax: (852) 2890-8469
電子郵件 Email : info@naturalhealing.com.hk
網址 Web Site: www.naturalhealing.com.hk

Homeopathic Case Record

No.: **Date:**

Name: **Age:**

Sex: _____ **Date of Birth:** _____**yr**_____**mth**_____**day**

Birth Time: _____**hr**_____**min (AM / PM)**

H.K.I.D. No.: _____ **Occupation: (Nature of Work)**

_____

Telephone No.: **Address:**

Home- **Flat/Room** _____ **Floor** _____ **Block** _____

Office- **Building** _____

Mobile- **No.** _____ **Street/Road** _____

Fax- **District** _____

Country _____

Postal Code _____

Email: _____

I would like to receive newsletter from :

☐ **Optimum Health Centre**

☐ **Sourcewadio.com**

In what language :

☐ **Chinese** ☐ **English**

Referred by: _____

採用: 自然療法、脊骨神經科、同類療法、針炙、營養療法、按摩、芳香療法、水療、浣腸療法、草藥療法、電腦測試及各類健康用品食物、書籍等。

Practice of: Naturopathy, Chiropractic, Homeopathy, Acupuncture, Nutrition, Massage, Aromatherapy, Hydrotherapy, colonics, Herbalogy, Computerized Therapeutic Testing, Various Health Products, Food, Books, etc.

If the question is not applicable, please fill in the **X** symbol.

2

If the question is not applicable, please fill in the X symbol.(Confidential)
*** (Please read each question carefully and then give your considered answers)**
MAIN COMPLAINT AND OTHER ASSOCIATED TROUBLES: (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES)

- ORIGIN OR CAUSE: Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, exposure to cold, heat etc.)

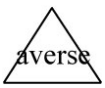
Mention the other following details of your health. Describe particularly and in detail ALL THE CHANGES OR STRANGE SYMPTOMS NOTICED after the onset of the present illness. Omit nothing. Try to describe the EXACT LOCATION and EXACT SENSATION of each complaint and the VARIOUS FACTORS AND CIRCUMSTANCES WHICH INCREASE OR DECREASE each trouble.

- Do you ever feel faint? If so, under what circumstances?
- Do you have giddiness? If so, describe how and when it is worse?
- Have you anything to complain about your head?
- Do you get headaches? If so, describe in detail when it comes, how it increases, where it starts and spreads etc. (mention if you have any trouble with your:)
    - Eye or Vision:
    - Ears or Sense of hearing:
    - Nose or Sense of smell:
    - Face or Facial expression:
    - Mouth or Sense of taste:
        - Is there Dryness or Salivation?
        - Tongue: (Describe its appearance)
            - Is there any crack, indention, trembling etc.?
            - If coated, describe colour and nature of coating:
        - Teeth:
        - Lips
        - Gums, e.g. bleeding:
        - Throat or Swallowing (including tonsils)

---

*When answering the questions GIVE MAXIMUM POSSIBLE INFORMATION INCLUDING ALL DETAILS. If the space provided for the answers is insufficient write on a separate paper and attach. Describe particular ALL PECULIARITIES you might have noticed about yourself. Remember the prescription depends upon the fullness and correctness of the information you give?

Crave - Please use the circle to select 

Averse - Please use the triangle to select 

APPETITE: What particular foods or drinks do you strongly crave for or you are strongly averse to: e.g. salty, sour, hot chilli, sweet, savory food, milk, eggs, fatty and fried food, cold drinks, coffee, tea, alcohol etc.?

How hungry do you feel: less, normal or unbearable? And what time?

What is the quantity of food you take now; same as, less or more than your original?

Is there any trouble after food; such as pains, burning, heaviness, sleepiness etc.?

THIRST: How much water do you take at a time and how many times in a day?

Do you prefer warm, ordinary, cold or iced?

ABDOMEN: Do you have bloating of abdomen? If so, when?

Do you pass gas? Up or down? Does it give relief?

RECTUM & ANUS: Is there any pain, burning, prolapse, piles, etc.?
If so, is it more before, during of after stool?

STOOLS: How many times do you pass?

Mention the quantity, colour and consistency.

Has it any bad smell?

URINE: Mention frequency, quantity, colour, smell etc.;

Any difficulty in passing? Is the flow slow to start, interrupted, feeble, dribbling etc.?

Do you find it easier to pass in any particular position?

How often do you pass at night?

Any involuntary urination?

Is there burning? If so, is it worse before, during or after urination?

SEXUAL SPHERE: Have you Excessive desire, Aversion etc.?

Do you suffer from sexual disturbances?

Do you suffer in any way after intercourse? If so, describe how.

For Men:

Do you have night emission?

Any inability to perform or quick ejaculation?

For Women:

Menses: How are the periods; regular or irregular?

At what age did it start? Was there any trouble then?

Mention interval between and No. of days of flow:

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

If the menses have stopped, state how you feel after that.

Do you suffer in any way before, during or after Menses? If so, describe:

Do you feel better or worse, during or after the Menses?

Do you feel the internal parts coming down?

Is there any leucorrhoeal (white) discharge?

If so, mention the nature, colour, consistency and smell of the discharge and when and under what circumstances it is more or less.

Do you catch cold often? If so, how?

Is there any trouble in your chest or heart?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

If so, when, in which position and under what circumstances is it worse?

Do you have cough?

Describe when and under what circumstances the cough is worse.

Is it dry or moist? Describe the nature of the sputum if any.

Do you have any trouble in your back, limbs or joints? Describe in detail.

If you have any pains, do they shift? In what direction do they extend?

Is there any complaint of skin: such as discolouration, itching, eruptions, ulcers, warts etc. (Describe its nature)

Is there any complaint with the Nails?

Is there any complaint with the Hair such as falling, graying, poor or excessive growth etc.?

SLEEP: How is your sleep?

Your posture in sleep: lying on the back, side, abdomen etc.:

Are you able to sleep in any position?

Do you feel refreshed or worse after sleep?

Do you get dreams?

If frequent, mention nature of dreams and objects generally seen.

SWEAT: How much, on what parts and when?

Is it warm or cold?

Is it sour-smelling or bad smell?

Does it stain the clothes?

Do you get fever or chill frequently? If so, what brings it on?

When does it come on?

Have your weight or size increased or reduced recently or after onset of the illness?

If so, is it noted more in any particular part?

Are you troubles one-sided?

Or more on one side?

Do they proceed from one to the other side?

Or do they alternate or shift?

Do wounds heal slowly?

Do wounds tend to form pus?

Have you a tendency to bleed?

Is there any trembling? If so, when and under what circumstance?

STATE HOW YOU ARE AFFECTED BY OR HOW YOU REACT TO THE FOLLOWING: ARE YOU UPSET OR RELIEVED BY ANY OF THESE?

1. Warmth in general: warmth of bed, of room etc.: Upset / Relieved
2. Cold in general: cold air, winds etc.: Upset / Relieved
3. Weather: dry, wet, cold, cloudy etc.: Upset / Relieved
4. Thunderstorms: Upset / Relieved
5. Open air; Fanning: Upset / Relieved
6. Near the sea and on the mountains: Upset / Relieved
7. Movement and rest: Fast & Slow motion: Upset / Relieved
8. Position and Posture:
   Lying down on the back, sides, abdomen etc.: Upset / Relieved
   Sitting, standing, rising, stopping etc.: Upset / Relieved
   Looking up, Looking down etc.: Upset / Relieved
9. Touch, Pressure and Massage: Upset / Relieved
10. Light, Noise, Smell etc.: Upset / Relieved
11. Sleep, Nap etc., or Loss of sleep: Upset / Relieved
12. Eating and Drinking: Upset / Relieved
    Before, during and after:
    Fasting: Upset / Relieved
    Particulars of items of food & drink which affect you or make you sick: e.g. Cabbage, Cold drinks, Eggs, Fats, Fish, Fried foods, Fruits, Milk, Onions, Potatoes, Pulses, Sour foods, Sweets etc.
13. Emotion; Anxiety, Grief, Joy etc.: Upset / Relieved
14. Exertion: Mental and Physical; Reading, Speaking etc. Upset / Relieved
15. Company, crowds etc.: Upset / Relieved
16. Ascending and Descending the stairs, in a lift etc.: Upset / Relieved
17. Bathing & Washing: cold, warm etc.: (Do you like a bath?)
18. Exposure to Sun: Upset / Relieved
19. Sweating, Passing Urine, Stool etc.: Upset / Relieved
20. Passing gas up or down: Upset / Relieved
21. Clothing etc.: woolen, cotton, Tight clothing: Upset / Relieved
22. In what part of the 24 hours do you feel best or worst?
23. Traveling: in bus, train, plane etc.: Upset / Relieved
24. Do your troubles occur or become worse periodically:
    e.g. daily, on alternate days, weekly, fortnightly, monthly, yearly, during new moon, full moon etc.?
25. Do they occur suddenly slowly or disappear suddenly/slowly?
26. Weather and Seasons: Summer Upset / Relieved, Winter Upset / Relieved, Cloudy Upset / Relieved, Rainy Upset / Relieved etc.:
27. Jarring, Jerking etc.: Upset / Relieved
28. Music & Dancing: Upset / Relieved
29. Change of position: Upset / Relieved
30. How is your health if you are constipated or have diarrhea?

HAVE YOU NOTICED ANY MARKED CHANGES IN YOUR MENTAL STATE? IF SO, DESCRIBE FULLY.

Have you became: (Please circle the answer)

Anxious or afraid of anything such as animals, being alone, darkness, death, diseases, robbers, sudden noises, thunder, high places etc.?

Doubtful? Suspicious?

Impatient? Hurried? Slow?

Offended easily?

Irritable? Quarrelsome? Violent? Abusive, etc?

Depressed, Sad, Brooding etc.?

Diffident? Or Proud?

Disgusted of anything? Or Suicidal?

Jealous?

Changeable? Or Indecisive?

Shy? Timid? Cowardly?

Indifferent to anything such as business, relatives etc.?

Restless?

Nervous or Excitable? If so, what happens to you when you are nervous?

Silent or talkative?

Sexual-minded?

Are you very affectionate?

Do you weep or sigh easily; if so, what makes you weep? How do you feel after weeping?

How do you like and react to sympathy?

How do you like and react to contradiction?

Do you suppress your feelings?

Have you any imaginary feelings or fears?

Do you get started? If so, when?

How is your mental capacity and memory?

Do you make mistakes? If so, of what type?

Do you regret anything?

Are you seriously worried or unhappy over any personal, domestic, economical, social or any other problems? If so, describe the situation in detail:

PREVIOUS HISTORY:

State ALL major illnesses suffered so far (including accidents, food poisonings etc.) such as Malaria, Typhoid, Measles, Small pox, Pneumonia, Pleurisy, etc., with approximate dates and duration. Mention whether you completely recovered your health after each.

(Women should mention abortions, miscarriages etc., if any, and the condition of their health during pregnancy.)

Have you ever suffered from any serious shock, grief, disappointments, fright, mental upset, etc.?
If so, describe in detail:

Is their any abnormality, swelling, numbness, paralysis etc., in any part of the body?

Did you suffer from any skin disorder? If so, how was it cured?

Did you suffer from any venereal disease?

Have you been vaccinated? How often? With what results?

Are you used to alcohol, smoking, tea, coffee, tobacco, or any drug etc. (mention quantity)

Have you ever had any accident? Any injury to the body or head?

Did you ever become unconscious? If so, when and how long?

Are aluminum vessels used for preparing or storing your food?

Did you have any bad habits?

Were you bitten by any animal, or poisonous insects?

For Children:

At what age did teething, walking and talking start?

Were growth and development normal?

Did the mother have any illness during pregnancy?

Was the child born at full term? By normal delivery?

FAMILY HISTORY: State age and condition of health of the following: (If anyone is not alive, state age at and the cause of death)

Father: Mother:

Brothers & Sisters: Married or Single:

Partner (Wife or Husband): Year of Marriage:

Children living (if any children died, state causes):

Any abortions or still births:

Did any relative of yours suffer from anemia, cancer, diabetes, insanity, rheumatism or tuberculosis?

PREVIOUS TREATMENT: State all the medicines and treatments (including operations and their results) taken so far (as far as you know) and the results:

Please list the name of the medicine and supplement you are taking now:

_____

_____

(TO BE FILLED IN BY A PHYSICIAN)

Physical Examination:

Appearance, Decubitus, Galt, etc:

Digestive System:

Respiratory System:

Circulatory System:

Urogenital: Locomotor:

Skin:

Weight: Height: Temp:

Pulse: B.P.: Resp:

Special Findings:

Laboratory Findings:

Blood:

Urine:

Stool:

Sputum:

X-Ray: ECG:

Diagnosis:

Treatment: