Homeopathic case taking form

A reusable record for practitioners and supervised students. Separate the person's words, observations and interpretation. This is a documentation aid, not a diagnostic instrument or a prescribing protocol.

Use a case code rather than identifying details for teaching. Replace the bracketed prompts when editing, or print and write in the spaces. Duplicate the symptom page as needed. Store completed records under the practice's applicable privacy and consent arrangements.

Case code and session

[Code, date, time, practitioner, initial visit or review]

Participation and permission

[Who is present; information source; consent and any recording permission]

The person's priorities in their own words

[What brought them here; what they want help with; exact wording]

Health context and coordination

Current medical care and relevant history

[Diagnoses, assessments, medications, allergies and other care; label unknowns]

Clinical concerns and actions

[Assessment or escalation by the responsible clinician; action, owner and date]

Agreed next contact

[Purpose, responsible person and date; record any clinician's safety instructions]

The form does not set a safe waiting period or recommend changing prescribed treatment. Record medical decisions and their source rather than inferring them from a repertory result.

Symptom and source record

Case code _____ Date _____ Symptom number _____
Repeat this page for each concern. An unanswered question stays unanswered; do not complete it from a remedy picture.

Exact words and context

[Quote the person; distinguish a carer's report or a direct observation]

Onset location and sensation

[Timeline, where it occurs, how it is described; note what is not known]

Modalities timing and accompanying features

[What changes it; when; what happens alongside it; how consistently]

Function and agreed observation

[Impact on ordinary activities; a repeatable observation to review]

Keep interpretation traceable

Candidate rubric and source

[Repertory, displayed edition, exact full path, language and date checked]

Fit limits and rejected alternatives

[What the wording supports; what it does not support; questions to clarify]

Materia medica reference and practitioner notes

[Author, book, entry, section or page; quotation separate from interpretation]

Case follow up record

Case code _____ Review date _____
Link this page to the original record. Describe changes against the same baseline before interpreting them. A change after an intervention does not by itself establish its cause.

Since the last contact

[The person's exact account and priorities; source of each observation]

Comparison with the baseline

[Same symptom, activity or measure; previous and current values; dates]

Other changes and care

[Medical review, medicines, routines, exposures or other plausible influences]

New concerns and clinical action

[New or worsening problems; responsible clinician, action and timing]

Source review and remaining uncertainty

[Recheck exact references; retain contradictions and unanswered questions]

Agreed plan and next review

[Record the clinician's plan and safety instructions, owner and date]

In Similia, selected notes can be entered into an ordinary case manually. This document has no automatic import. Free includes three new cases and three analyses each month; creating a practice case uses those allowances. Notes-to-Rubric and other AI toolkit features require Pro.