CASE-TAKING

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In case-taking the first thing to understand is that from the homoeopathist's viewpoint there are two distinct kinds of information to be sought. One deals with the clinical and diagnostic side of the case and is the kind of information sought by all diagnosticians of whatever school. The other kind of information sought deals with those manifestations which indicate the homoeopathic remedy required for cure, and these manifestations are seldom observed and never sought by any except homoeopathists.

Thus a case can be perfectly taken from the clinical standpoint and yet the history gives no hint of the curative remedy. On the other hand, all the indications for a homoeopathic remedy can be brought out without giving a hint of the diagnosis.

It is axiomatic that a properly taken case-history should record all the facts necessary for both therapeutic and diagnostic study.

Analysis of all the evidence on which diagnosis depends reveals a focussing of the mind on the damage that has been done to different tissues and the bacterial or other factors which have caused the damage.

Analysis of the evidence on which homoeopathic remedy is selected shows that evidence to be those symptoms which represent the kind of resistance the body puts up against the factors that cause the disorder. This latter analysis is much more subtle than the former.

A tabulation of all diagnostic and therapeutic evidence shows that this evidence falls into natural groups and these groups can be arranged schematically so as to form the foundation for a rational routine in case-taking.

For obvious reasons a patient's history should be couched in language that means the same thing to everybody. To this end the patient should be directed to tell *his* story in *his own way* and the record should be made, as far as practicable, in his *own* language. He should not be interrupted except to bring him back to his case when he seems inclined to wander, or else to have him explain what he has not expressed clearly at first. Unnecessary interruptions break the continuity of his thoughts and he is likely to forget symptoms or to state them differently than he would if encouraged to spontaneous expression.

The physician ought to follow a routine based on the requirements of a history adequate for all purposes. But his system of taking the case ought to be only a prompter for himself and not for the patient, so that when finished he can check it up and see that all points have been covered.

He should follow the patient absolutely in the unfolding of the history in whatever direction it goes.

History-blanks. The best history-blanks are plain sheets of thin paper that go in envelopes which fit whatever filings-case is used.

THE PATIENT'S STORY

The best starting-point is some equivalent of 'now tell me all about your troubles in your own way.' The stereotyped question, 'what is your chief complaint?' or 'when were you last perfectly well?' may be needed in some cases, but for rontine use they are too suggestive.

Write down each item, leaving a space where necessary for amplification. Excepting when a patient wanders in his story the only interruption should be to hold him back from talking faster than the record can be made. After each pause start off again with the question 'what else?' and this question 'what else?' should be repeated until the patient answers, 'that is all'.

Most of the symptoms will have been expressed in general terms and without their distinguishing characteristics. And so after the patient has told all he can think of in his own way each point should be taken up and amplified. Here questions must be put, and the general rule should be observed never to put direct questions which can be answered by 'yes' or 'no', for then the patient is apt to take his cue from the question and reply as he thinks that the questioner expects him to.

Put all questions so that the patient must think of his symptoms and describe them in his own language. The spontaneous history fully amplified should cover all information under the following five heads:

Objective symptoms.
Subjective symptoms.
Location.
Modalities.
Cause.

The objective symptoms come under the first head as—

Conditions: These must be fully described, e.g. swellings should be described as to size, shape, color, hardness, fluctuation, induration, temperature, etc.; discharges as to consistency, color, acridity, odor, etc.; ulcers as to size, shape, depth, color, margins, discharge, etc.; skin lesions in general, according to the standard descriptive terms, such as papules, pustules, etc.; cough, as to its being dry or loose-sounding, paroxysmal, hacking, spasmodic, etc.

Subjective symptoms come under the second heading as—

Sensation: All sensations must be described as to character and intensity. Such sensations as stiffness, numbness, itching, tingling, etc., are definite enough for universal understanding. Some are given in descriptive terms, such as 'sensation of a hair on the tongue', 'white of egg dried on the face', 'crawling like insects on the skin', or 'worms crawling beneath the skin', etc. and ought to be recorded as described.

A painful sensation is likely to be mentioned by the patient only as

'pain', and he must be asked to describe its exact charaeter. Keep in mind such terms as burning, bursting, cramping, cutting, soreness, stitching, throbbing, etc. Ascertain whether the pains come or go quickly or slowly, cover large or small areas, whether they are wandering or fixed, and whether they radiate or extend in any direction or go from side to side, or go from below up, or from above down.

The third point that must be covered is—

Location: The location of every condition and every sensation must be described. This applies not only to the part of the body affected but, also, when possible, to the organs or the tissues involved. Note also whether the complaints are right-sided or left-sided, or one side above and the opposite side below.

The fourth point to be covered is the condition of aggravation and amelioration; these are known as—

Modalities: Boger, with keen insight, defines them as the natural modifiers of sickness. They should be obtained with accuracy, for the modalities are the soul of the symptoms. Concerning every symptom should be put, the questions, 'when is it better or worse?' and 'what makes it better or worse?'

The principal modalities have to do with:

(1) Time of day or night periodicity, season.

(2) Temperature, weather, open air.

(3) Position, motion, touch, pressure, jarring, light, noise, eating, drinking, sleep.

If the patient does not volunteer any modalities, ask him specifically if his symptoms are affected by any of the above.

In disturbances of the special functions of the eyes, ears, nose, mouth, throat and the digestive and sexual tracts, not only the above-mentioned modalities will apply, but others related to the functions of each part will suggest themselves.

The fifth point to remember is:

Cause and sequence: To know the cause of an illness is always important. Question carefully to ascertain this. Also get a careful description of the prodrome, the onset, and the sequence of the symptoms, and when they began.

Keep in mind the words, *why*, *when* and *how*. Find out if the symptoms are changeable or constant. Note particularly the relation of the symptoms to one another; and whether there is an alternation of different symptoms; and note those which have a concomitant relationship, such as sweat whilst drinking, restlessness with pain, red face with cough, hot head with cold extremities, etc.

All of the foregoing have to do, with the details of the patient's complaint as they appeal to him. The next natural step is to consider the patient as a whole. Mankind is divided into groups, one group of which is worse from heat, another from cold; another in wet weather, another in dry weather, etc.

All of these general reactions are constitutional marking and are known as generalities—

GENERALITIES

To locate a patient in his constitutional group, a good approach is something like this: "You have told me what makes your headache and your cough better or worse, now tell me whether you are better or worse, that is to say, generally better or worse, regardless of any special part of the body, at any special time of the day, or from heat, cold weather, etc". Generalities, except those affecting special functions fall under four heads the principal ones being: time, temperature (weather etc.), position (motion, etc.) and effect of external impressions.

Time: Time of day or night, season, periodicity.

Temperature, weather, etc.: Cold, heat, wet or dry weather, thunderstorm, wind-storm, before a storm, cloudy weather, change of weather, warm room, out of doors, sun draught, bath, taking cold easily.

Position, motion, etc.: Standing, sitting, lying, exercise, lying on the painful or on the painless side, or on the right or on the left side, mental exertions, etc.

Effects of external impressions: Light, noise, music, odors, touch, pressure of clothing or of neckband etc.

In case-taking vividness and accuracy are the sine qua non for correct interpretation, and in no branch of the science is it more imperative than in obtaining modalities and generalities. Note the degree of intensity of each modality. For instance, a mere preference for heat or for cold is not sufficient to constitute a good modality unless it be impossible to obtain something more positive. To be really striking there must be actually an aggravation or an amelioration from heat or cold. A strong modality or generality may be the dominant factor in finding the cure for the patient. Remember that the patient may volunteer, or the symptoms may suggest other modalities equally important, but the ones mentioned are the most usual ones and should be kept in mind when questioning.

The next natural step is to investigate the major functions of the body.

FUNCTIONS

Digestive Functions: Begin with alternation of taste, such as a bad, bitter, metallic, lack of taste, etc. Also the circumstances of alternation, such as bad taste in the morning, water tastes bad, bread tastes bitter, food lacks taste, etc. Then appetite, which may be ravenous, lacking, capricious, quickly satiated; loathing of food; appetite good but losing flesh, etc. Inquire about cravings and aversions, such as craving or aversion for salt, sour or sweet things, fat food, etc. Ask about aggravation from special articles of food, as for example, milk, meat, farinaceous food, etc. Ask also about thirst, whether patient is thirsty for large or small amounts, or if he is without thirst. Inquire

too if cold or warm food or drinks are craved and whether either cold or warm food or drink aggravates. Inquire about eructations or vomiting, character of either and associated circumstances. Find out if there is a general aggravation or amelioration after eating or drinking.

Then inquire as to the bowel functions: if constipated, this may be with urging or without desire for stool, or constipation with soft stool, or alternating constipation and diarrhoea. If there be diarrhoea, ascertain all the modalities and the associated symptoms, and in both diarrhoea and constipation note the character of the stool.

Remember that discharges of any kind characterise the patient.

Next may be taken up the:

Sexual functions: Any abnormality of the sexual function should be elicited, such as weakness, impotence, sterility, emissions, general aggravation after coitus, etc. Enquire particularly about menstruation: at what age it commenced, its regularity, whether it is early or late, profuse or scanty, protracted or of short duration; character of discharge. Be sure to ascertain whether the patient is in general better or worse either before, during or after menstruation. Inquire as to leucorrhoea, its character and modalities.

Next can be taken up:

Sleep: A patient may be too sleepy or sleepless. If sleepless, he may be wide awake from active thoughts or sleepy yet unable to sleep. Sleepiness may be constant or at unusual times, or it may develop into stupor. The patient may be restless in his sleep or wake frequently or wake from slight noises, or he may talk or cry out or jerk in his sleep, or wake with a start or wake frightened. If he dreams ask what is the character of his dreams and learn whether he assumes any particular position during sleep. Note whether there is any general aggravation or amelioration after sleep.

The fourth function that may be taken up is:

Skin: Inquire as to its texture, whether it is too oily or too dry. Ask if the patient perspires easily and under what conditions, or whether there is inability to perspire. Inquire whether there is local perspiration, as for instance, on head, hands, feet, or axillae, and its character. Ask also if the patient is in general better or worse after perspiring. Enquire about local coldness or heat of the skin such as cold hands or feet, or hot head, hands or feet. Find out if there are any eruptions and if the skin heals readily.

In chill, fever and sweat, ascertain if they come in normal sequence or if they occur independently of one another, or irregularly, and all concomitant symptoms and modalities during each stage and between the stages.

THE MIND

Last but not least in this schema of functions comes the mind.

Homoeopathists have always considered mental symptoms to be of the highest importance, because they accurately express an individual's adjust-

ment to his environment and characterise him more than any other functional derangement.

Mind is left as the last section in the schema of functions because the searching questioning up to this point gains the confidence of the patient and leads him, both voluntarily and involuntarily, to reveal his mental state.

Roughly mental symptoms are divided into two classes: those which deal with the intellect and those which deal with the emotions.

Symptoms of the intellect deal with those attributes involved in voluntary effort, such as memory, concentration, etc.

Emotional symptoms have to do with involuntary attributes and include the loves and hates of the individual.

Numerous classifications are possible but it is sufficient to keep in mind that there are two main groups of symptoms: the irritable and the depressed groups, any of which symptoms may be objective or subjective.

In the irritable group are irritability, hurry, restlessness, intolerance of pain, the quality of being easily startled, etc. A secondary group under this heading includes the aberrations such as delirium, delusions, loquacity, jealousy, suspicion, haughtiness, etc.

The depression group includes depression, sadness, sensitiveness, despair, indifference, aggravation from consolation, suicidal thoughts or tendencies, etc.

A secondary group under this heading includes the fears and aversions.

In garrulous or imaginative or fearful patients, often their obvious mental condition is of much more importance than are the specific things of which they complain.

In connection with the mind, remember the etiological relation that mental shocks bear to some cases, such as excitement, fear, anger, grief, mortification, etc.

The last step in taking the case-history is to pick up any information not falling under previous heads, under miscellaneous.

MISCELLANEOUS

Anatomic survey: In giving his story and in reviewing the major functions the patient may have forgotten some points, so it is advisable to inquire systematically about each part of the body beginning with the hair and ending with the nails.

In this survey symptoms referable to the nervous system, organs of special senses, cardio-vascular, respiratory and urinary organs may be elicited.

The *personal history* can be taken up next.

This is best considered in seven-year periods. Inquire if he was well as a child and if not in what way he was ill and from what cause. Ask specifically about children's diseases, mentioning each and if possible learning their sequence. Ask about other diseases, mentioning the usual acute ones

such as rheumatism, pneumonia, typhoid, tuberculosis, sore throats, frequent colds, adenoids, appendicitis and venereal diseases.

If possible get the characteristics of each previous illness, its cause, the treatment and the state of health afterwards.

Inquire about injuries, operations and their results.

Ascertain about vaccination and prophylactic innoculation. In women investigate the history of miscarriages, pregnancy and labour.

Then take up the habits of the patient.

This should include his environment, such as place of residence, place of business and kind of occupation, exercise, food, drink, tea, coffee, tobacco, alcohol and drugs. In the matter of food it is well to have him describe his average breakfast, lunch and dinner. In the matter of drugs, remember cathartics, patent medicines, strong tooth and mouth-cleansers, foot and axilliary sweat suppressers, etc.

The *family history* should take into consideration not only the father, mother, brothers and sisters, but often the grandparents, uncles and aunts. A man inherits his possibilities of longevity and his powers of resistance. Common heredity-factors are tuberculosis, syphilis, gout, epilepsy, insanity, arthritis, renal and arterial diseases and many others. Some hereditary factors have a protean form; e.g., some members of a family group may have gout, another asthma, another hay-fever, all having one common heredity. In another family group, insanity, hysteria, epilepsy, criminal and alcoholic tendencies may develop.

In chronic cases particularly, valuable information can be had from study of the family history.

Find out which parent the patient resembles more.

Objective appearances: Finally, note the general appearance of the patient; his build and complexion; color, abundance and distribution of the hair; shape, size, symmetry and proportions of the head, face, eyes, ears, nose and hands. Note the cowlicks, worms in hair, lines of face, forehead, warts, moles and birthmarks. Observe the posture, gait, restlessness and twitchings if any, or other disorders of movement.

Note the general behavior, expression of face and eyes, state of intelligence, speech, etc.

Note condition of mouth and tongue and relation of pulse, temperature and respiration to one another.

In infants and unconscious persons everything is objective and every deviation from normal must be accurately noted.

Some of this last part belongs to the routine of the physical examination, but as these observations are all essential and as the history is the first step toward the examination, they are not out of place here.

Now add to this history all the physical and laboratory findings and the case is ready for both diagnostic and remedy study.

This sounds like a formidable amount of detail to master but a glance

at the sequence of the steps reveals it as a procedure where each step leads naturally to the next. It begins with that which lies on the top of the patient's mind and leads by natural association of ideas through the patient's own experiences to the most remote influences of his existence.

One has merely to keep in mind the four divisions:

First, the patient's story with five points to be covered:

Conditions.
Sensations.
Location.
Modalities.
Cause and sequence.

Second, Generalities of which there are four general types:

Time.
Temperature, weather, etc.
Position, motion, etc.
General sensitiveness to external impressions.

Third, General functions under five heads:

Digestive functions.
Sexual functions.
Sleep.
Skin.
Mind.

Fourth, Miscellaneous under four heads:

Anatomical survey.
Personal history.
Family history.
Objective symptoms.

Remember that the schema is only a systematised grouping of points essential in a fully taken case, and it is only for the physician so that he may check himself off and know whether he has covered everything.

The patient should commence his story in his own way and continue it as it comes to him, regardless of where the symptoms are listed in the schema.

No attempt is made here to show short cuts, for everything in the case enriches one's knowledge of the patient. It pays to go intimately into all cases, for although much that is observed in a given case cannot be relationships, it assumes definite significance.

MacKenzie made polygraph tracings for twenty-five years without being able to interpret many points, but later knowledge based on all his observations revealed the significance of all that he had failed to understand.

Only long experience enables one to ignore that which is non-essential to the immediate need in a case, and only in experienced hands are short cuts safe.

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