Dr Awanti Dhadphale, B.H.M.S. Reg. No.42636

Patient Informed Consent & Liability Waiver

1. Voluntary Participation & Accuracy

I, the undersigned, voluntarily choose to undergo homeopathic treatment. I declare that the information provided regarding my medical history, symptoms, and lifestyle is accurate to the best of my knowledge.

2. Scope of Homeopathic Treatment

I understand that Homeopathy is a holistic system of medicine. I acknowledge that results may vary based on individual constitution and adherence to the prescribed regimen. I agree to keep the doctor informed of any new symptoms or concurrent treatments from other systems of medicine.

3. Medicolegal Waiver

I understand that homeopathic advice provided via online/digital formats is based on the symptoms reported by me. In case of acute emergencies, I agree to seek immediate assistance from the nearest local emergency healthcare facility.

4. Right to Withdraw*

I reserve the right to withdraw my consent for treatment at any time by providing written notice.

Acknowledgment

I have read and understood the terms above.

I willingly agree to undergo the treatment.

Digital Signature / Thumb Impression: _____

Date: _____

Dr Awanti Dhadphale, B.H.M.S. Reg. No.42636

HOMOEOPATHIC CASE RECORD

1. Patient Identification

Name of Patient		**Age / Gender**	
Referred By		**Occupation**	
Name of Company		**Email ID**	
School Name		**Standard**	
Contact Number		**Emergency Contact**	
Address			

2. Clinical History

Chief Complaints			
Duration & Location		**Associated Complaints**	
Family History		**Childhood History**	
Surgical History		**Medical History**	

3. Physical Generals

Diet (Veg/Non-Veg)		**Thirst (Litres/Day)**	
Desires / Aversions		**Bowel Habits**	
Urinary Complaints		**Perspiration**	
Thermal (Best Season)		**Fan Requirement**	
Sleep Position		**Sleep Duration/Timing**	
Sleep Quality		**Dreams / Nightmares**	
Weight	In Kg	**Height**	In Cm

4. Mind & Interpersonal

Nature of Person	
Stress Factors	
Interpersonal Relations	
Childhood Details	

5. Menstrual / Obstetric History

Last Menstrual Period		**Flow Consistency**	
Number of Days		**Abortions (if any)**	
Regular/ Irregular		**First menstrual cycle**	

Patient/Guardian Signature: _____

Date: _____