WissHom
Wissenschaftliche Gesellschaft für Homöopathie
Scientific Society for Homeopathy

Project Case Documentation - Documentation Standard

Data collection covers the following areas:

1. Patient data
2. Medical history
3. Homeopathic case taking
4. Physical findings
5. Case analysis
6. Prescription
7. Follow-up examinations

Optional information is indicated accordingly.

1. Patient ID	1. [In-house only: last name, first name, address, sex, date of birth] 2. [In-house only: insurance and billing details if applicable] 3. For anonymised case collection: in-house patient ID and, usually, year of birth
2. Therapist ID	1. [Optional: last name, first name, address], area of operation, therapist ID for case collection
3. Case ID	1. Definition acute/chronic 2. Diagnosis (see 10.) 3. Treatment date or dates
4. Homeopathic case taking	1. Spontaneous report, controlled report (inquiries made, indicated accordingly); for individual symptoms locality, quality, modalities, first onset, triggers, progress over time, concomitant symptoms; for recurring symptoms frequency and correlations with biological rhythms; other observations 2. Selection of important literal statements made by patient, complete symptoms, totality of symptoms 3. History of vegetative disorders (chronic cases) 4. Social history, occupation (chronic cases) 5. [Optional: comprehensive verbatim transcript]
5. Previous diseases, medical history	1. All (incl. diagnoses and treatment, vaccinations, operations, infectious diseases, pregnancies, births, medication, previous complementary methods used) (chronic cases)
6. Family history	1. All diseases in the family (chronic cases)
7. Constitution (optional)	1. Physique, physical features, characteristics with no disease value
8. Findings	1. Physical examination (incl. height, weight, general health, nutritional state), relevant laboratory results 2. Relevant instrumental diagnostic examinations 3. Poss. photographs, results from elsewhere (in-house only, not to be shared within central documentation system due to data privacy law)
9. Case analysis (symptoms)	1. Patient's key complaints (main symptoms), characteristic symptoms [definition: symptoms describing the individual case that differ from other, similar illnesses (noticeable, strange, unusual, peculiar symptoms according to Hahnemann, ORG [Organon of the Art of Healing] § 153)] 2. Indicative symptoms for prescription 3. Symptoms relevant to disease course 4. Other significant symptoms and modalities 5. Aetiology (if relevant), all medical observations

10. Diagnosis	1. Disease name(s), duration of disease to date, acute/chronic, stage (if identifiable), intensity of main complaint as judged by patient (and/or practitioner) on numeric rating scale (0-10) 2. [Optional: intensity of secondary complaints] 3. [Optional: other outcome parameters] 4. Expanded diagnosis list (accompanying symptoms, beyond treatment contract), ICD-10 codes for diagnoses
11. Drug/drug ID	1. Rationale for choice of remedy (e.g. repertorisation, corresponding symptoms of MM, other methodological reasons) 2. Exclusion of other homeopathic remedies (differential MM comparison) 3. Drug name, manufacturer, potency 4. Dosage form (pharmaceutical form) 5. Usage instructions (dosage, duration and method of administration) 6. [Optional: comment (e.g. intermediates, nosodes, intercurrent prescription)] 7. [Optional: certainty of prescription, e.g. numeric rating scale]
12. Concomitant treatments	1. Further prescriptions and recommendations 2. Other medication 3. Other methods (incl. dietary) 4. Other involved practitioners/therapists 5. Self-treatment
13. Therapeutic agreement	1. Is homeopathic treatment possible, or possible as an adjunct? 2. Definition of treatment goals, decision whether homeopathic treatment is possible alone or concomitantly 3. Other, or regular diagnostic procedures 4. Follow-up appointment(s)/reattendance
14. Course	1. Every follow-up consultation (by phone or in person) (consult ID), change in main complaints, intensity of main complaints according to the patient (and/or practitioner) on numeric rating scale (0-10) – causal assignment to prescription (drug ID) as judged by the practitioner 2. Change in other relevant symptoms [poss. scale: intensity of secondary complaints] 3. [Optional: estimation of bias factors, e.g. differentiation from the effects of other (concomitant) treatments or from the spontaneous course of the disease] 4. [Optional: other outcome parameters, comparison of treatment outcome with first-mentioned treatment goal. Follow-up period after cessation of treatment] 5. New choice of treatment with rationale (see 9.-12. Case analysis to concomitant treatment) 6. Summary assessment of course (e.g. initial exacerbation, improvement as per Hering's Rule, suppression), special observations over the course: 7. new symptoms, return of old symptoms (poss. modified), Hering's Rule 8. Intercurative drug proving symptoms 9. Addition(s) to case taking (e.g. hitherto unmentioned symptoms and possibly their disappearance) 10. [Optional: other comments on the case and course]
15. Keywords	e.g. suppression, Hering's Rule