PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

You have come here to get well. We are here to select the best possible medicine for you. In order to do that, we depend on your co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order find all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is useless. Even something that you may think is not connected with your trouble, may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give us the fullest possible information on each point*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential.

THIS QUESTIONNAIRE HAS 8 PARTS :

1. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
2. History of your present illness.
3. About all the parts of your body.
4. Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specifi effects they have on you.
5. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.
6. About your sleep and dreams.
7. For children or how you were as a child.
8. In this part you are given instructions on how to report each of your complaints. Read the instructions first Then make a list of your complaints and describe each of them according to the instructions.

Adult Registration Form

Name_____ Birth date_____ Age_____

Home Address_____ Phone_____

City, Zip_____ Phone_____

Business Address_____ Phone_____

Email_____

Sex M F Usual Occupation_____ Employer_____

Living Situation □ alone □ parents □spouse □ friend(s) □ boarding

Referred by_____

Marital Status □ never married □ now married □ divorced □ widowed

Number of children_____ Number living with you_____

Employment Status □ school □ keeping house □ work □ full time □ part time □ unemployed
□ disabled □ retired

Person to be contacted in case of emergency_____

Address_____ Phone_____

Members of household

Name	Age	Relationship

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: By signing this document, I hereby authorize the staff of the Hahnemann Medical Clinic, Dr. Nancy Herrick DH (Hon), P.A. and Roger Morrison M.D., to treat me using homeopathic medicines according to the principles of homeopathic practice. I understand and acknowledge the Hahnemann Medical Clinic staff will base their treatment decisions on the school of homeopathic practice, and if I desire to be treated according to the orthodox or allopathic school of medicine, I am free to seek such treatment from another physician. In some cases I may be encourage or required to do so. I understand that Nancy Herrick and Roger Morrison act as homeopathic specialists and not as primary care providers. I understand the Hahnemann Medical Clinic will make the best effort to treat me but makes no guarantees that their homeopathic treatment will cure me. I also authorize Hahnemann Medical Clinic to video tape my interviews for the use of inter-staff consultation on my case and/or for the use of teaching students of homeopathy. I certify that the above information is true and give the examining practitioner permission to contact previous practitioners.

I understand that charges will made and herby agree that I am financially responsible for any such charges.

Signature_____ Date_____

Do you use: Amount

☐Coffee _____

☐Cigarettes _____

☐Alcohol _____

☐Aspirin _____

Please list any drug allergies below

_____

_____

_____

_____

Please list all medications including supplements — Dosage

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

	Allergies	Anemia	Arthritis/Gout	Asthma	Bleeding/Bruising problems	Cancer or Tumors	Convulsions/Epilepsy	Diabetes	Drinking or Drug problem	Eczema	Emphysema	Heart Trouble	Henatitis	High Blood Pressure	Frequent Infections	Kidney or Bladder problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problems
You																															
Father																															
Mother																															
Siblings																															
Children																															
G. Parents																															

Last Three Hospitalizations (except normal pregnancies)

	Hospitalization (1)	Hospitalization (2)	Hospitalization (3)
Type of operation or illness			
Month and year hospitalized			
Name of hospital			
City and State			

If you have had any of the following tests or immunizations place an (X) next to the appropriate box and, if you can, give the year you last had them.

Year	Test	Year	Immunizations
_____	☐Chest x-ray	_____	☐Smallpox
_____	☐Kidney x-ray (Pyelogram)	_____	☐Tetanus
_____	☐G.I.series	_____	☐Polio
_____	☐Colon x-ray (Barium enema)	_____	☐Typhoid
_____	☐Gallbladder x-ray (Cholecystogram)	_____	☐Flu
_____	☐Electrocardiogram	_____	☐Mumps
_____	☐T.B. test	_____	☐Measles
_____	☐Other x-rays	_____	☐Other

PREVIOUS DISEASES & DRUG USED

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus your body is strengthened. Thus it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illness so far suffered and on the next page give its relevant details.

<table>
<tr><td>Typhoid
Cholera
Food poisoning
Worms
Diarrhoea
Dysentery</td><td>Measles
German Measles
Chicken-pox
Small-pox
Mumps
Whooping cough</td><td>Malaria
Jaundice
Any Liver
Spleen or
Gall bladder
disease</td><td>Miscarriage
Abortion
Currettings
Sickness during
Pregnancy etc.
Prolapse of uterus</td></tr>
<tr><td>Malnutrition
Rickets
Rheumatism
Backache</td><td>Any venereal
disease like
Syphillis
Gonorrhoea etc.</td><td>Any heart
trouble,
Blood pressure,
Giddiness</td><td>Nephritis (Kidney or urine
trouble) Diabetes etc.
Prostate trouble</td></tr>
<tr><td>Any operation such as
Tonsils, Abdomen, Appendix,
Hernia, Piles Uterus, Renal
stones, Gall stones, Phimosis,
Hydocele, Cataract etc. Mode
of anaesthesia : general-local</td><td colspan="2">Diptheria, Septic Tonsils, Adenoids
Recurrent infections-Sinusitis
Bronchitis-Eosinophilia
Cold-Fever-Chill. Pneumonia
Asthma-Pleurisy-T. B.</td><td>Any serious shock, grief,
disappointments, fright, mental
upset, depression or nervous
break down.</td></tr>
<tr><td>Chronic Headaches,
Numbness,
Cramps, Fits, Convulsions
Polio, Paralysis etc.
Meningitis -
Any Lumbar puncture done.</td><td colspan="2">Any major accident or
injury to body or head.
Any occasion of unconsciousness.
Any major bleeding from any part of the body.</td><td>Skin diseases like Pimples,
Boils, Carbuncles, Ringworms,
Fungus, Scabies, Eczema.
Herpes, Urticaria, Allergy.
Ulcers on any part of the body.</td></tr>
</table>

Diseases suffered from	Approximate Age	Duration	Whether you completely recovered	Medicines & treatment taken	Any other particulars

Any extra remarks or information

Mention any drugs, tonics, stimulants etc. that have been used by you at any time in life

* How many brothers - sisters are you? (including those who died, if any)
Provide information about them in the table below, Indicate your position by writing 'SELF'.

Sr. No	Brother / Sister	Alive / Dead	Age	Diseases Suffered
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PERSONAL HISTORY

*About your birth :
Did your mother have any problem during pregnancy?
Did she take any drugs during pregnancy? What were they?
Was there any difficult about your birth? Give Details.

*At what age did you start.

Teething	
Sitting	
Standing	
Walking	
Speaking	

Urine control / bed-wetting etc.	
Eating indigestibles like chalk, lime, earth, slate-pencil etc.	
Any other problem about your growth & development?	

Tick mark (✓) if any animal bites such as:

Dog		Rat		Snake		Scorpion	

Mention if any order:

Did you take anti-rabies or anti-venom or any other treatment ?

MAIN COMPLAINTS AND OTHER ASSOCIATED TROUBLES : (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES).

ORIGIN OF 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, overexposure to cold, heat etc.)?

APPETITE AND THIRST

How is your appetite ?

When are you hungry ?

What happens if you have to remain hungry for long ?

How fast do you eat ?

How much thirst do you have ?

Any particular time are you specially thirsty ?

Do you feel any change in your taste and feeling in your mouth ?

Please put one tick (✓) if you Like/ Dislike the food or if the food disagrees. Put two marks (✓✓) , if you strongly Like / Dislike the food or if the food strongly disagrees.

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Bitter				Eggs			
Salt extra				Spicy food			
Sweet				Meat			
Sour				Fish			
Bread				Cabbage			
Butter				Onions			
Fats				Warm food / drink			
Milk				Cold food / drink			
Coffee				Fruits			
Lemon				Smoked flavored			
Vinegar				Anything else			
Cheese							
Strong Cheese							

STOOL

Do you have any problem regarding your stools ?

When and how many times a day you pass stools ?

When is it urgent ?

Do you have any problem about bowel movements ?

Do you have to strain for stool? Even if soft ?

Do you have belching or passing gas ? Describe its character.

How do you feel after passing gas up or down ?

URINATION & URINE

Any problem about urine ?

Any strong smell? Like what ?

Do you have any trouble before, during and after passing urine ?

Any difficult about the flow Slow to start, interrupted, feeble, dribbling etc. ?

Any involuntary urination ? When ?

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat ?

Where and on what part do you sweat most ?

Do you perspire on the palms or soles ?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?

What is the smell like ? e.g. foul, pungent, sour, urinous.

What colour does it stain the clothing ?
Is the stain easy to wash off or difficul ?

Any symptoms after sweating ?

When do you get fever or chill ?

What brings it on ?

Do you experience any sense of heat or cold in
any part of your body at any particular time ?

Do you have burning or heat in your palms or soles ?

CHEST - HEAT - COLD - COUGH

Do you catch cold often ? If so, how ?

Describe the symptoms, nature of discharge etc.
Is there any trouble with your CHEST or HEART ?

Is there any trouble with your voice or speech ?

Is there any difficulty in breathing ?

Do you have cough ?
Is it more at any particular time ?

SEXUAL SPHERE (GENERAL)

Any excessive indulgence in sex in past and present ?
Any effect on your health ?

How do you feel after sexual intercourse ?
Any particular feeling or symtoms appear before, during or after sexual intercourse ?

Do you suffer from any sexual disturbance ?

Any habit like (masturbation etc.) in past
as well as present ? How often ?

Did you suffer from any sexually transmitted disease ?
Syphilis ? Gonorrhoea ? Herpes ? HIV ?

Did you have increased desire or decreased desire for sex ?

What is the method you use for family planning (contraception) ?

FOR MEN

Any difficult in erection ?

Wanted erection ? Unwanted erection ?

Weak erection ? Failing erection? Describe.

Any other trouble in sex ? Describe in details.

FOR WOMEN

Menses : How are the periods; regular or irregular ?

At what age did you start ?

Was there any trouble then ?

Mention interval between two periods.

Mention number of days of flo .

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

Are the stains difficul to wash ?

Have you noticed any variation in quality
and quantity of flo during menses ? How and when ?

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

What symptoms did you suffer during menopause ?

Do you feel internal parts coming down ?

Is there any white discharge ?
If so, mention the nature, colour, consistency
and smell of discharge.

When and under what circumstances is it more or less.
Has the discharge any relation to menses ?

What is the effect of this discharge on your
general feeling? Or any of your symptoms ?

Any itching, excoriation etc. due to discharge ?

Do you pass any gas from vagina ?

Any trouble with breasts ?

ANY COMPLAINTS ABOUT :

VERTIGO - Do you have giddiness - vertigo ?

FAINTNESS : Do you ever feel faint ?

HEAD : Do you get headaches ?

EYES & VISION :

EARS & Sense of hearing :

NOSE & Sense of smell :

FACE & Facial expression :

MOUTH & Sense of taste :

About LIPS, MOUTH, TONGUE etc. :

TEETH, GUMS, e.g. carious teeth, bleeding gums.
swollen gums.

LIPS : Cracked, peeling of skin etc.

THROAT (including tonsils) :
Any difficult in swallowing?

Do you have any trouble in your BACK, LIMBS
OR JOINTS? Describe in detail :

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

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

Is there any complaint of SKIN : such as
itching, eruptions ulcers, warts, corns,
peeling etc.? (Describe its nature)

Any change in colour of the skin or
spots of any part of the body ?
Is there any complaint or abnormality of
the NAILS or skins around ?

Is there any complaint with the HAIR such
as falling, graying, dandruff, dryness, oily , poor
excessive or unusual growth ?

Do wounds heal slowly ?
Form keloid? Do wounds tend to form pus ?
Have you a tendency to bleed ?

Are your troubles one sided? which one ?
Or more on one side ?
Do they proceed from one to the other side ?
Or do they alternate or shift ?

Is there any trembling ? When ?

Is there any senses of weakness ? Where ?
When is it more or less ?
Is it in any particular part of the body ?

FACTORS THAT AFFECT YOU

Below are the list of things that you are exposed to each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of the factors. In what way do they affect you. Please only indicate factors which have a distinct or important effect on you — not those which only slightly affect you.

For instance take the factor “sun”. Suppose by going in the sun you get a headache then write “Headache” opposite to “Sun”.

Take another example If in hot weather you feel uneasy, then write “Uneasy” opposite to “Hot Weather” in the column.

In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes worse”.

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause headache but make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

	Effect
Hot weather	
Cold weather	
Rainy weather	
Cloudy weather	
Change of season	
Thunder - storm	
Covering	
Warm bath	
Sun	
Cold bathing	

	Effect
Walking	
Running	
Climbing stairs	
Going downstairs	
Riding in bus, car etc.	
Lying	
Lying on back	
Lying on left side	
Lying on right side	
Lying on abdomen	

	Effect
Lying with head low	
Sitting	
Sitting erect	
Standing	
Looking up	
Looking down	
Looking from high places	
Looking from moving object	
Noise	
Sudden Noise	
Music	
Light	
Strong smells	
When constipated	
Before Urine	
During Urine	
After Urine	
Before Menses	
During Menses	
After Menses	
After Sweating	
When Fasting	
After eating	

	Effect
Drinking	
After sexual intercourse	
Dust	
Smoke	
Touch	
Pressure	
Massage	
Tight Clothes	
Before Sleep	
During Sleep	
After Sleep	
After afternoon nap	
Loss of sleep	
Before stools	
During stools	
After stools	
Coughing	
Sneezing	
Laughing	
Talking	
Reading	
Writing	
Stooping	

	Effect
Before important engagement	
Before exams	
When angry	
When worried	
When sad	
After Weeping	
Consolation / Sympathy	
In a crowd	
In a closed room	
When thinking of illness	
Full Moon / New Moon	
Morning	
Afternoon	
Evening	
Night	
Bathing	
Draft air	
Biting or chewing	
Blowing Nose	
When alone	
In company	
Physical exertion	
Belching	

	Effect
Passing gas	
After hair cut	
Combing hair	
Brushing teeth	
Moonlight	
Opening the mouth	
Smoking	
Hanging the limbs	
Raising the arms	
Near Sea	
Shaving	
Stretching	
Swallowing	
Listening to others talk	
Vomiting	
Yawning	
Moving the eyes	
Opening the eyes	
Closing the eyes	
Getting feet wet	
Over eating	
Working in water	
Fanning	

MIND

It is now universally acknowledged that your mind has tremendous influenc on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole.

In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental make up.

Answer freely. Answer frankly. Answer completely.

Are you anxious ? About which matters ?

Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc. ?

Are you doubtful or suspicious? Of what ?

What are you jealous about ? Of whom? From what symptoms do you suffer when jealousy ?

In which matter are you impatient ? Hurried ?

How long do you remember hurts caused to you by others ?

How much revengeful are you ?

What are you proud of ? Does your pride get easily hurt ?

Depress, Brooding, etc. ?

Do you ever become suicidal ? When ?
If so in what manner do you contemplate
to end your life ?
Even then, are you afraid of dying ?

When are you cheerful ?

Are you sexual-minded ?

Any unwanted thoughts any time ?
What are they ?

Have you any imaginary sensations or fears ?

Do you hear voices, or that you are called,
or anything else in this line keeps on
occurring in your mind unduly ?

How is your memory ?
For what is it poor? e.g. names, places,
faces, what you have read, etc.

Do you weep easily ?
What makes you weep ?
How do you feel after weeping ?

How do you feel if someone offers
sympathy and consolation ?

Are you easily irritated ?
What makes you angry ?

What bodily symptoms do you develop
when angry ? e.g. trembling, sweating etc.

Do you like company ? Or like to remain alone ?

How seriously are you affected by disorder
and uncleanliness in your surrounding ?

What are the greatest griefs that you have
gone through in your life ?
What are the greatest joys that you have had in life ?

What activities you deeply like ?
Are there any matters which you deeply dislike ?

In your opinion, which aspects of your mind and moods
are not agreeable to you. Inspite of your awareness
and maturity, are you unable to change these aspects ?

Give a clear cut picture of your situation in life and
your relationship with each of your family members,
friends and associates in work.

How does the future look to you ?

When you are free, what thoughts come to your mind ?

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

If asked for 3 desires or wishes in life, what will you ask for ?

S L E E P

Describe your posture in sleep,
on the back, side, abdomen etc.

Are you able to sleep in any position ?
In which position you can't sleep ?

During sleep do you :
Snore? Grind teeth ?
Dribble saliva? Sweat ?
Keep eyes or mouth open ?
Walk ? Talk ? Moan ? Weep ?
Become restless ? Wake up with a jerk ?

Describe if anything else is unusual
about your sleep : (Sleepy,
Sleeplessness, etc. if so when)

How much do you cover ?
Do you have to uncover any parts ?

Circle types of dream that you have

Animals Cats - Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death, Whose? Dead bodies Dead persons Part of Body Suicide
Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work
Vomiting Passing stool Urinating Blood-bleeding Excrements / soiling	Romantic Sexual Pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure / Exams Unsuccesful efforts ? For what ? **Missing** Train Being unprepared
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom ? - For what ?	Try to recall and list any very important or repeated dreams or nightmares.	
Of people Children Parties Feasts Marriage	Of events Remote Recents Future Prophetic	Physical Exertion Mental Exertion Fatigue Coloured Multi-Coloured		

Please draw something that comes to your mind at present or your favourite drawing:

YOU AS A CHILD

1) Please tick mark once (✓) if the child or you as child had any of the following qualities : Tick mark twice (✓✓) if they are more intense :

	Tick here		Tick here
Obstinacy		Unusual fears	
Temper tantrums		Shyness	
Disobedience		Unusual attachments (to whom)	
Aggression		Habits like :-	
Hyperactivity		Biting nails	
Destructiveness		Thumb-sucking	
Courage		Picking and playing with	
Possessiveness		(a) mother's body parts	
Competition - winning spirit		(b) shawls, handkerchieves	
Slibling jealousy		(c) anything else	
Any special skills		Religious	
Unusual desires (for what)		Dullness of memory	
Boasting		Slowness (in what)	
Stealing		Laziness / Indolence	
Telling lies		Sensitive / Emotional	

2) Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also describe the dreams the mother got during pregnancy.

3) Please describe any other aspects you feel are striking about the child.

4) Describe one incident from the child's life when he/she very upset.

HOW TO DESCRIBE YOUR COMPLAINTS

In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homoeopathic physician “I have a headache”, “an eruption”, or “cough”, would not be enough. If you inform him “I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool”, then only you have given all the information required for making a good homoeopathic prescription. *The success of the prescription depends, largely, on how detailed is your description of the symptoms.*

We require the following details about your symptoms.

LOCATION : Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figur on page 24 to indicate location.

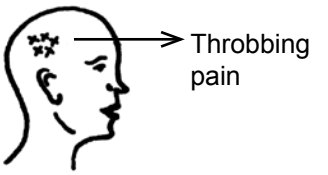
SENSATION : Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER : Many factors are likely to influenc your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on pages 14 to 16. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES : You may have a discharge from ulcers, fistula eruptions the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects.

* The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases ?
* The consistency; Is it thin or thick, stringy, or clotted ?
* Is it like jelly, white of an egg, like water, sticky, forming a scab etc. ?
* The odour, what does it remind you of ?
* Does it make the parts sore, and in what way ?

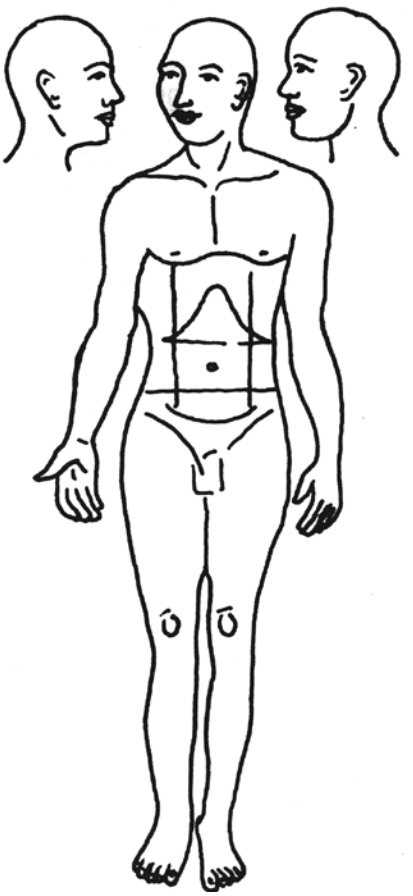
Please mark in the below figure the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of you head please mark as shown →



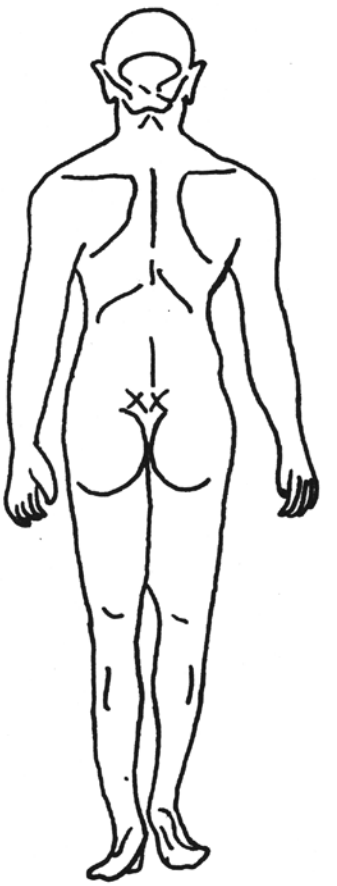
RIGHT FACE

FRONT

LEFT FACE



BACK



IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAIL IN THE MANNER DESCRIBED ON PAGE 24

COMPLAINT NO.	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE