International Journal of Trend in Scientific Research and Development (IJTSRD)
Volume 10 Issue 5, Sep-Oct 2026 Available Online: www.ijtsrd.com e-ISSN: 2456 – 6470

Modern Lifestyle and Changing Clinical Symptom Patterns: Implications for Homoeopathic Case-Taking and Repertorisation

Dr. Palak Chauhan[1], Dr. Prabhat Vaghamshi[2], Dr. Arpita Sheth[3]

[1]PG Scholer, MD Homoeopathy, Department of Repertory and Case Taking,
[2]Professor, [3]Associate Professor,
[1,2,3]Shri B. G. Garaiya Homoeopathic Medical Collage, Rajkot, Gujarat, India

ABSTRACT

Background

Modern lifestyles have undergone considerable changes due to urbanisation, digital technology, altered dietary habits, sedentary behaviour, irregular sleep schedules, and increasing psychosocial demands. These factors may influence health, disease risk, symptom severity, and patterns of healthcare utilisation. Contemporary patients may present with overlapping physical, psychological, and lifestyle-associated complaints, creating challenges for comprehensive clinical assessment.

Objective

To discuss the association between modern lifestyle factors and clinical symptom presentation and to examine their implications for homoeopathic case-taking and repertorisation.

Methods

This narrative review discusses established concepts and research areas concerning lifestyle factors, sleep, psychological stress, dietary patterns, physical activity, and digital behaviour. It also considers how these factors can be documented during clinical case-taking and interpreted within classical homoeopathic repertories. A systematic literature search and formal assessment of study quality are required before this draft can be considered a completed evidence-based review.

Discussion

Lifestyle factors may contribute to the onset, persistence, or exacerbation of several health complaints. Sleep disturbances, psychological stress, poor dietary patterns, and physical inactivity have been associated with conditions such as headache, gastrointestinal symptoms, fatigue, metabolic disorders, and selected skin diseases. However, these associations differ across conditions, and causality cannot be assumed. Detailed case-taking should therefore include lifestyle history, symptom chronology, relevant medical history, medication use, and appropriate diagnostic assessment. Classical repertorisation may help organise symptoms within the homoeopathic framework, but the adequacy of existing repertories for representing contemporary patient expressions requires systematic evaluation.

Conclusion

Modern lifestyle is an important consideration in contemporary clinical assessment. Integrating structured lifestyle history with evidence-based medical evaluation may improve the completeness of patient assessment. Further research is required to investigate whether classical homoeopathic repertories adequately represent contemporary symptom descriptions and whether repertorisation contributes measurable benefits to clinical decision-making.

KEYWORDS: *Modern lifestyle, clinical presentation, lifestyle factors, sleep disturbances, psychological stress, homoeopathic case-taking, repertorisation, chronic diseases.*

How to cite this paper: Dr. Palak Chauhan | Dr. Prabhat Vaghamshi | Dr. Arpita Sheth "Modern Lifestyle and Changing Clinical Symptom Patterns: Implications for Homoeopathic Case-Taking and Repertorisation" Published in International Journal of Trend in Scientific Research and Development (ijtsrd), ISSN: 2456-6470, Volume-10 | Issue-5, October 2026, pp.1685-1689, URL: www.ijtsrd.com/papers/ijtsrd142262.pdf

IJTSRD142262

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1. INTRODUCTION

Human lifestyles have changed substantially over recent decades. Urbanisation, technological development, changes in employment patterns, increased screen exposure, dietary transitions, and reduced physical activity have altered many aspects of daily life. These changes have important implications for public health and clinical practice.

Lifestyle is a broad concept that includes dietary habits, physical activity, sleep patterns, substance use, occupational conditions, social relationships, and psychological stress. These factors interact with biological, genetic, environmental, and socioeconomic determinants of health. Their combined effects may influence the development of disease, the severity of symptoms, recovery, and quality of life.

In contemporary clinical practice, patients frequently report combinations of fatigue, disturbed sleep, headaches, gastrointestinal discomfort, anxiety, and reduced concentration. Such symptoms are nonspecific and may have multiple explanations. They should not automatically be attributed to modern lifestyle without appropriate assessment.

For homoeopathic practitioners, the changing language and complexity of patient complaints present an additional question: how can contemporary symptoms be documented accurately and translated into the terminology used in classical repertories?

This question is particularly relevant to repertory and case-taking because the quality of symptom documentation influences subsequent symptom analysis. A systematic approach should preserve the patient's actual experience while distinguishing subjective symptoms from objective clinical findings and medically established diagnoses.

2. Objectives

1. To describe major lifestyle changes relevant to contemporary health.
2. To discuss associations between lifestyle factors and selected clinical presentations.
3. To examine the importance of lifestyle history in comprehensive case-taking.
4. To discuss challenges in translating contemporary patient expressions into classical repertory terminology.
5. To identify research priorities for evaluating repertory coverage and its clinical utility.

3. Major Lifestyle Changes in the Modern Era

3.1. Digitalisation and increased screen exposure

Digital devices are now widely used for education, employment, communication, entertainment, and healthcare. Prolonged screen use, particularly when it extends into the evening or displaces sleep and physical activity, may be associated with health complaints in some individuals.

Potentially relevant presentations include eye strain, neck discomfort, headaches, delayed sleep, and daytime fatigue. The relationship depends on factors such as duration of exposure, ergonomics, viewing habits, underlying health conditions, and individual susceptibility.

Screen exposure should therefore be assessed in context rather than treated as a universal cause of these symptoms.

3.2. Altered sleep patterns

Irregular work schedules, academic demands, late-night device use, shift work, and psychosocial stress can interfere with sleep duration and regularity.

Insufficient or poor-quality sleep may be associated with daytime sleepiness, fatigue, impaired concentration, mood changes, and reduced functioning. Persistent sleep complaints can also be associated with medical conditions, medication effects, and sleep disorders.

Clinical assessment should document bedtime, wake time, sleep duration, awakenings, perceived sleep quality, daytime effects, and the duration of the problem.

3.3. Dietary transitions

Changes in food availability, eating schedules, and dietary preferences have influenced dietary patterns in many populations. Frequent consumption of energy-dense, nutrient-poor foods may contribute to an unhealthy dietary pattern, particularly when combined with physical inactivity.

Dietary habits may be relevant when assessing obesity, metabolic disorders, constipation, reflux symptoms, and selected nutritional deficiencies. However, individual symptoms should be evaluated for other possible causes.

A useful dietary history includes meal timing, food variety, hydration, restrictive diets, supplement use, and any reproducible association between food intake and symptoms.

3.4. Sedentary behaviour and reduced physical activity

Mechanised transport, desk-based employment, prolonged study, and screen-based recreation may reduce daily movement.

Insufficient physical activity is associated with several adverse health outcomes, including increased cardiometabolic risk. Prolonged sedentary behaviour

may also contribute to musculoskeletal discomfort, particularly when posture and workstation ergonomics are poor.

Assessment should distinguish total physical activity from sedentary time. A patient may exercise regularly but still spend much of the day sitting.

3.5. Psychosocial stress

Academic pressure, employment insecurity, financial difficulties, caregiving responsibilities, social isolation, and continuous digital communication may contribute to psychological stress.

Stress can affect sleep, appetite, concentration, emotional well-being, and the perception or severity of some physical symptoms. It may also coexist with medical conditions that require independent assessment.

Symptoms such as palpitations, headaches, abdominal discomfort, and fatigue should not be labelled psychological solely because the patient reports stress. Relevant medical causes must be considered.

4. Lifestyle Factors and Clinical Symptom Presentation

Lifestyle factors may influence symptoms through several pathways, including behavioural, physiological, psychological, and environmental mechanisms. The strength of evidence differs according to the factor and the health condition.

4.1. Sleep disturbances and fatigue

Fatigue is a common but nonspecific complaint. Inadequate sleep may contribute to fatigue and impaired concentration, but other causes include anaemia, thyroid disorders, infection, medication effects, mood disorders, and chronic medical conditions.

A detailed clinical history should establish onset, duration, severity, aggravating factors, associated symptoms, and functional impact.

4.2. Stress and gastrointestinal complaints

Psychological stress and gastrointestinal symptoms can interact. Some patients report changes in abdominal discomfort, bowel habits, or symptom severity during stressful periods.

These associations are relevant to conditions involving interactions between the brain and gastrointestinal system. Nevertheless, persistent or severe symptoms require assessment for gastrointestinal and other medical disorders.

Clinical documentation should include the nature and location of discomfort, relation to meals and defecation, bowel frequency, associated symptoms, medication use, and alarm features.

4.3. Lifestyle factors and headache

Headaches may be associated with sleep disruption, stress, dehydration, irregular meals, prolonged visual tasks, and musculoskeletal tension in some individuals.

These factors are not sufficient to establish a headache diagnosis. Clinical assessment should consider the headache pattern, duration, frequency, associated symptoms, medication use, neurological findings, and warning signs.

A sudden severe headache, new neurological deficit, altered consciousness, or other concerning features requires urgent medical assessment.

4.4. Lifestyle and skin disorders

Stress, sleep disturbance, environmental exposures, and personal care practices may be relevant to the course of selected skin conditions. Their importance varies by diagnosis.

For example, psychological stress may exacerbate symptoms in some people with inflammatory skin disorders, while acne is influenced by several interacting biological and environmental factors.

Skin complaints should be assessed using appropriate diagnostic criteria, clinical examination, disease-specific severity measures, and relevant treatment history. Lifestyle advice should complement, not replace, indicated medical care.

4.5. Lifestyle and metabolic health

Dietary patterns, physical inactivity, sleep, and socioeconomic circumstances may influence cardiometabolic risk. Relevant conditions include obesity, type 2 diabetes, and hypertension.

These conditions may remain asymptomatic for prolonged periods. Their identification therefore depends on appropriate screening, clinical evaluation, and laboratory measurements rather than symptom-based assessment alone.

This distinction is important: a change in lifestyle does not necessarily produce a noticeable change in clinical symptoms, and the absence of symptoms does not exclude disease.

5. Implications for Homoeopathic Case-Taking

Homoeopathic case-taking traditionally places emphasis on a detailed account of the patient's complaints and experiences. Regardless of the therapeutic framework used, accurate history-taking is fundamental to clinical assessment.

Modern lifestyle factors can be incorporated into case-taking through a structured history.

5.1. Presenting complaint

Record the principal complaint in the patient's own words before translating it into technical terminology. Document onset and duration, frequency and progression, location and character, associated symptoms, aggravating and relieving factors, previous episodes and treatment, and effect on daily activities.

5.2. Lifestyle history

Relevant questions include: What time do you usually sleep and wake up? How many hours do you sleep? Do you use digital devices before bedtime? What is your usual meal pattern? How much physical activity do you perform? Do you use tobacco, alcohol, caffeine, or other substances? Have there been recent changes in work, study, family circumstances, or stress? Do you notice any consistent relationship between these factors and your symptoms?

Questions should be neutral and should not lead the patient towards a presumed explanation.

5.3. Medical and psychosocial assessment

A comprehensive history should include previous illnesses, current medication, allergies, family history, relevant investigations, and psychosocial circumstances.

Objective examination and appropriate diagnostic testing should be performed when indicated. Lifestyle-related explanations must not delay the investigation of serious or treatable conditions.

5.4. Longitudinal symptom documentation

Repeated assessment can help determine whether a symptom is persistent, intermittent, recurrent, improving, or worsening. Useful variables include symptom frequency, symptom intensity, duration of episodes, functional impairment, sleep quality, relevant lifestyle exposures, and concurrent treatments and clinical findings.

Validated instruments should be selected according to the condition under investigation. Changes in symptoms should not automatically be attributed to a particular treatment because natural fluctuation, regression to the mean, concurrent interventions, and other factors may influence outcomes.

6. Challenges in Classical Homoeopathic Repertorisation

Classical repertories organise symptoms into standardised rubrics. Their use in contemporary practice raises questions about terminology, coverage, interpretation, and reproducibility.

6.1. Differences in patient language

Modern patients may describe their experiences using expressions associated with digital work, irregular schedules, information overload, or contemporary social demands. These expressions may not correspond directly to a single repertory rubric. The clinician must identify the underlying symptom without distorting the patient's meaning.

For example, a patient who says, “My mind keeps working even when I want to sleep,” may be describing difficulty initiating sleep, persistent thinking, anxiety, or another experience. The appropriate clinical documentation depends on clarification rather than immediate rubric selection.

6.2. Distinguishing symptoms from explanations

A patient may believe that a complaint is caused by mobile phone use, work pressure, or a particular food. This belief is important to document, but it does not independently establish causation. The observed symptom, the patient's interpretation, and the clinician's assessment should be recorded separately.

6.3. Repertory coverage

A relevant research question is whether contemporary patient expressions can be mapped reliably to existing repertory rubrics. This could be investigated by collecting de-identified patient expressions from clinical records; developing a predefined list of contemporary symptom descriptions; mapping these descriptions to rubrics in a specified repertory edition; recording direct, approximate, or absent matches; asking independent reviewers to assess the mappings; and measuring agreement between reviewers.

Such a study could provide measurable information about repertory coverage. It would not, by itself, demonstrate the effectiveness of repertorisation or any homoeopathic treatment.

6.4. Digital repertorisation

Digital repertory platforms may facilitate searching, cross-referencing, and organising rubrics. However, search convenience does not guarantee clinical accuracy. A digital system should be evaluated for source transparency, terminology, completeness, reproducibility, and the accuracy of its mapping between patient expressions and repertory rubrics.

7. Research Gaps and Future Directions

Several areas warrant further investigation. First, contemporary patient language may not always correspond neatly to the terminology used in older repertories. The extent of this problem should be measured rather than assumed.

Second, research is needed to determine whether different practitioners select similar rubrics when presented with the same standardised patient descriptions.

Third, lifestyle factors should be documented using clear operational definitions. Terms such as stress, poor sleep, sedentary behaviour, and digital overuse require measurable criteria.

Fourth, observational studies could examine associations between selected lifestyle factors and symptom frequency or severity in clearly defined patient populations.

Fifth, clinical studies should use validated outcome measures, appropriate comparison groups where feasible, and transparent reporting methods when evaluating interventions.

Finally, studies of repertory utility should distinguish between the ability to represent symptoms, the consistency of rubric selection, the usefulness of repertorisation in clinical decision-making, and patient outcomes. These are different research questions and require different methods.

8. Limitations

This article is a narrative review draft rather than a completed systematic review. It does not report a reproducible search strategy, formal study selection, risk-of-bias assessment, or quantitative synthesis.

The relationship between lifestyle factors and clinical symptoms varies by condition and individual. Many associations are influenced by confounding factors, and not all associations establish causation.

The discussion of repertorisation identifies questions for investigation rather than demonstrating that classical repertories are inadequate or that repertorisation improves clinical outcomes.

The article also does not establish that homoeopathic treatment modifies the underlying course of lifestyle-associated diseases. Such claims require appropriate clinical evidence.

9. Conclusion

Modern lifestyle factors, including sleep disruption, dietary patterns, physical inactivity, digital behaviour, and psychosocial stress, are important considerations in contemporary healthcare. Depending on the condition, these factors may be associated with the occurrence, persistence, or severity of clinical complaints.

For homoeopathic case-taking, a structured lifestyle history can help provide a more complete account of the patient's circumstances and symptom patterns. Accurate documentation should preserve the patient's language while distinguishing subjective experiences, objective findings, and established diagnoses.

The adequacy of classical repertories for representing contemporary patient expressions is a worthwhile research question. Systematic repertory-content analysis, inter-rater agreement studies, and well-designed clinical research could help clarify their coverage and practical utility.

Ultimately, contemporary clinical practice requires careful history-taking, appropriate diagnostic assessment, transparent evaluation of evidence, and measurable patient outcomes. The relationship between modern lifestyle, symptom presentation, and repertorisation should be investigated through reproducible research rather than assumptions.

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