

Chronic Disease History Form

Please Email Or Fax This Form To Us Before Your Appointment.

You Must Save Your Form Before Emailing Or No Data Will Be Sent.



Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Birthdate _____ Sex _____ Marital Status _____ Home Phone _____
 Work Phone _____ Fax _____ Email _____
 SS# _____ How were you referred? _____
 Occupation _____ Employer _____
 In case of emergency contact _____
 Relation _____ Home Phone _____ Work Phone _____
 Name of Spouse _____ Occupation _____
 Employer _____ Work Phone _____
 Insurance Company _____ Policy # _____
 Name of Insured _____ Birthdate _____

General: Please mark X on any conditions you have or have had:

Digestion	Liver	Nose	Thyroid	Constipation
Stomach	Lungs	Mouth	Spine	Diarrhea
Colon	Heart	Esophagus	Rectum	Asthma
Blood	Brain	Hair	Lymphatic	Allergies
Muscle	Pancreas	Scalp	Circulation	Psoriasis
Fat	Spleen	Skin	Fatigue	Eczema
Bone	Gall Bladder	Immunity	Chronic Pain	Restless Leg
Nervous Sys	Eyes	Infections	Joints	Concentration
Reproductive	Ears	Colds	Insomnia	Emotions

Your Condition: Briefly describe your condition.

When were you first diagnosed with this condition? _____

Is there a family history of this condition? _____

How severe are your symptoms? _____

How has the condition progressed since it began? _____

Name and Phone number of current physician:

Please list any medications or nutritional supplements you are taking:

Medication or Supplement	Purpose	Taking for How Long
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Please list any allergies you have to foods, drugs or other substances:

Substance	Reaction

What is your doctor's opinion about the prognosis of your condition? _____

How would you characterize the success or side effects of the treatments you have been receiving?

Are you satisfied with your current medical treatment? _____

Please rate the overall intensity of your imbalances on a scale of 1 – 10. (1: mild, 5: moderate, 10: severe) _____

Is your sleep disturbed by the symptoms of your condition(s)? _____

To what extent are you having any degree of bodily pain or discomfort? _____

To what extent do your symptoms interfere with your daily activities? _____

How often are you having pain or discomfort? _____

How long does the pain or discomfort last on the average? _____

How would you rate your usual energy level compared to most people on a scale from 1 – 10 with 1 being very low energy, 5 average and 10 being very high energy? _____

Are you tired or rested when you wake up? _____

How well have you been able to cope with your regular activities and responsibilities? _____

Please mark X on any conditions you have or have had:

Trembling		Nervousness	
Sleeplessness		Light Headedness	
Weight Loss		Intolerance to Cold Temperatures	
Intolerance		Excessive Perspiration	
Anger and Irritability		Burning Sensations in the Body	
Reddish Color of the Skin		Increased Frequency of the Bowel Mvts	
General Heaviness in the Body		Recurring Sore Throat/ Swollen Glands	
Skin Feels Cold to Touch		Lethargy	
Depression/Hopelessness		General Itching	

How often do you have bowel movements? _____

When do you usually have bowel movements? _____

Are the stools usually soft, medium, hard ? _____

Do you have any of the following urinary problems? _____

Have you ever taken frequent enemas or used laxatives in excess? _____

Sleep Is: (Mark X on any that apply)

Sound and of normal duration		Light & Interrupted	
Too little sleep		Too Heavy & Long	
Difficulty Falling Asleep		Difficulty Waking Up	
Awaken Too Early		Frequent Nightmares	

To what extent do you experience anxiety, worry, or nervousness? _____

Do you work with computers or with chemicals or in a polluted environment? _____

Is your work environment polluted? _____

What is your body build? _____ Small Frame _____ Medium Frame _____ Large Frame

What is your present state of mind and emotions? __ Excellent __ Good __ fair __ poor

What time do you fall asleep? _____

What time to you get up? _____

When do you eat Breakfast? _____

When do you eat Lunch? _____

When do you eat Dinner? _____

Do you skip or delay meals? _____

Do you have snacks between meals? _____

Do you travel a lot? _____

Do you sleep during the daytime? _____

How regular is your daily routine? _____

Do you often experience any of the following?

Worry _____ Fear or Panic _____ High Stress Level _____ Anxiety _____

Do you delay or suppress any of the following?

Bowel Mvts _____ Gas _____ Urination _____ Sleep _____ Vomiting _____
 Yawning _____ Burping _____ Breathing _____ Hunger _____ Thirst _____

How often do you exercise? _____

Is your exercise: ___ Vigorous ___ moderate ___ light ___ don't exercise

Is your diet? ___ Vegetarian ___ non-vegetarian ___ mostly vegetarian

Do you smoke? _____

If so how many packs/day? _____

How often do you consume alcohol? _____

What type of weather makes you feel most uncomfortable:

Cold _____ Hot _____ Cool & Damp _____

Section for women only:

How regular is your menstrual period? _____

How many days does your menstrual period last? _____

How heavy is your menstrual flow? _____

Associated symptoms (before or during menstruation)

___ None ___ Pain ___ Acne ___ Tension ___ Fluid retention ___ Depression ___ Migraine

Do you have any discharge outside of your menstrual period? ___ no ___ yes, color _____

Are you pregnant _____

Do you take contraceptive pills? _____

Number of previous pregnancies: _____

Please Acknowledge The Following By Checking The Box:

- I have read and agree with your privacy policies (<http://www.drdougbeech.com/Privacy-Policy.html>)
- I have read and agree with your payment policies (<http://www.drdougbeech.com/Payment-Policies.html>)

For Medicare Patients Only:

- According to your Medicare Carrier Trailblazer, current regulations require patients to sign a waiver of liability on every visit. This is to insure that you understand the treatment you receive on a given day may be considered "medically unnecessary" by Medicare Standards & payment denied. Your signature on your History form indicates you understand this condition of treatment.

